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IMPRESSUM

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Liebe Leserinnen und Leser!

Nach zwei Ausgaben der Zeitschrift im Jahr 2004, die sich speziell auf die Regionen Afrika und Lateinamerika bezogen, liegt nun das Heft mit dem Schwerpunkt Asien vor. Was ist spezifisch an Asien? Kann man diesen riesigen Kontinent als eine Einheit beschreiben, in der Themen, Aussagen und Entwicklungen ebenso auf den Nahen Osten wie auf Südostasien, ebenso auf den indischen Subkontinent wie auf Sibirien, Indonesien und China zutreffen? Dies aufzuzeigen ist nicht unser Anliegen und würde der Vielfalt der Länder und Kulturen Asiens nicht gerecht werden. Im vorliegenden Heft wollen wir vielmehr durch eine Auswahl von Artikeln und Berichten mit verschiedenen Schwerpunkten aufzeigen, wie unterschiedlich und kulturell spezifisch das Thema Behinderung im jeweiligen Kontext und auf ganz unterschiedlichen Ebenen angegangen wird. Dennoch ziehen sich bestimmte Themen und Begriffe durch diese Ausgabe, die in ihrer Aktualität für die jeweilige Situation von mehreren AutorInnen aufgegriffen werden, wie *Community Based Rehabilitation* (CBR) und die Frage des Einflusses westlicher Konzepte auf die Praxis in verschiedenen Ländern.

Thomas/Thomas geben einleitend einen Überblick über die Entwicklung von CBR, von einem Verfahren, angemessene Rehabilitationsdienstleistungen für alle Menschen mit Behinderung zugänglich zu machen, hin zu einer Bewegung, die den Selbstbestimmungs- und Menschenrechtsaspekt in den Mittelpunkt stellt und damit ein wichtiges Moment für die gleichberechtigte Teilnahme von Menschen mit Behinderung an Entwicklung darstellt. Diese Verschiebung des Selbstverständnisses von CBR hat sicher nicht nur in Asien stattgefunden, und sie wird auch nicht in allen Ländern Asiens gleich verlaufen sein. Aber das Beispiel aus Vietnam, vorgestellt in dem Artikel von *Hanh/Hanh/Maarse*, zeigt auf, welche Funktion Selbsthilfeorganisationen von Menschen mit Behinderung innerhalb eines CBR-Programmes haben und wie wichtig ihr Beitrag für die Effektivität und Nachhaltigkeit der CBR-Maßnahmen, besonders für die Integration von Menschen mit Behinderung in die Gesellschaft, ist.

Thomas Friedrich beleuchtet in seinem Beitrag die geschichtliche Entwicklung und heutige Situation der Sonderpädagogik in Indien, die sowohl in ihren Anfängen als auch dem heutigen Erscheinungsbild stark von westlichen Einflüssen geprägt ist. Trotz der Entwicklung von Ansätzen, die der lokalen Situation besser entsprechen und mehr Menschen erreichen sollen,

wie CBR- und Integrationsprogramme, bleiben weiterhin Menschen aufgrund der Schwere ihrer Behinderung ausgeschlossen. Weiterreichende, ganzheitliche Ansätze bieten sich nach Ansicht des Autors durch die Einbeziehung von indischen Naturheilmethoden.

Ein konkretes Beispiel aus Indien, das sich auf Menschen mit einer geistigen Behinderung bezieht, wird in dem Beitrag von *Zimmermann/Felix* beschrieben. Das vom *Central Institute on Mental Retardation* in Trivandrum entwickelte „3 Cs Concept“ wird als ganzheitliche Methode sowohl in der häuslichen Betreuung im Rahmen eines CBR-Programmes als auch in Schulen angewandt.

Auch in der Rubrik „Berichte“ sind mehrere asienspezifische Beiträge zu finden: So befasst sich der Beitrag von *Lubetzky/Shvarts/Galil/Tesler/Vardi/Merrick* mit den Folgen der Einführung der Zuzahlungspflicht auf die Nutzung von Therapieangeboten in Israel. Der Vergleich von Familien unterschiedlicher Herkunft (jüdische Israelis und israelische Beduinen) über drei Jahre legt nahe, dass die Art des Therapieangebots auch kulturelle Aspekte mit einbeziehen sollte.

Ingar Düring beschreibt in ihrem Bericht die vor zehn Jahren in Bangladesch entwickelte CAHD-Strategie, die den Behindertenaspekt als Teil umfassender Entwicklung betrachtet. Anhand von mehreren Beispielen verdeutlicht sie, wie Projekte innerhalb vorhandener staatlicher und anderer Strukturen funktionieren, so dass die Einbeziehung von Menschen mit Behinderung in die Gemeindeentwicklung gewährleistet ist.

Ein Interview zur Arbeit der ILO in den arabischen Ländern, ein Beitrag über das Thema „Alter und Behinderung“ von der Konferenz der *Indian Association of Women's Studies* und Berichte über die Konferenz zu *Inclusion and the Removal of Barriers to Learning, Participation and Development* in Indonesien sowie über die *Asian and Pacific Decade of Disabled Persons* runden den Themenschwerpunkt ab.

Viel Spaß beim Lesen wünscht

Ihre Redaktionsgruppe

Community Based Rehabilitation as a Tool for Inclusion and Empowerment of Persons with Disability

Maya Thomas/M.J. Thomas

Community Based Rehabilitation (CBR) can be considered as the most significant development over the last twenty-five years, in the field of rehabilitation of persons with disability in less developed countries. CBR was initiated as a method to improve coverage of services for persons with disability living in rural areas, and has undergone many shifts and changes in the way it is conceptualised and practised. This paper traces the development of CBR from a service delivery approach that promoted wider coverage of services, to a strategy for inclusion and rights promotion.

Introduction

Globally, the disability rehabilitation scenario today is at an exciting stage. After many years of effort, there are moves towards a UN Convention on rights of persons with disability, which will be a major step forward, and binding on governments to protect the rights of their disabled citizens. At the regional level, the *Asian and Pacific Decade of Disabled Persons* (1993-2002) is extended from 2003 to 2012, and the *Biwako Millennium Framework* (UNESCAP 2003) is being followed in this region for programmes for people with disability. The period 2000-2009 was formally proclaimed the *African Decade of Disabled Persons* in June 2002. The African Decade seeks to replicate the practices of the Asian and Pacific Decade. The *Arab Decade of Disabled People* was launched in 2004. All these international statements focus on rights and inclusion of persons with disability.

From a developing country perspective, one strategy that is doing much today to promote equal opportunities, social inclusion and rights of persons with disability, is *Community Based Rehabilitation* (CBR). CBR is considered as the most significant innovation over the last twenty-five years in the field of rehabilitation for persons with disability, especially for those in rural areas in developing countries. This paper traces the development of CBR from a service delivery approach that was started initially to promote wider coverage of services, to a strategy for inclusion and rights promotion.

CBR in the eighties

Although different forms of non-institutional rehabilitation were known to exist some centuries ago, *Community Based Rehabilitation* gained formal recognition and world-wide acceptance with its promotion by *World Health Organisation* and other UN agencies in the early eighties (WHO 1981, UN 1983). It was promoted as a suitable method to rehabilitate people with disability living in rural areas in developing

countries, who hitherto had had no access to services. Since developing countries had limited resources to provide extensive coverage of high quality services for their disabled citizens, the emphasis was on evolving a method that would provide wide coverage, at costs that were affordable to governments of these countries. Implementation of this method involved shifting rehabilitation interventions to homes and communities of people with disability, to be carried out by minimally qualified non-professionals such as families and other community members, thereby reducing costs of setting up expensive institutions (WHO 1989).

In the early eighties, CBR was conceptualised and evolved primarily as a service delivery method with a medical focus, since WHO had recommended that it should be integrated into primary health care system that was already well established in many developing countries. The *International Classification of Impairments, Disabilities and Handicaps* (ICIDH) published in 1980 by WHO also contributed to a medical approach (WHO 1980). With these influences, early CBR programmes tended to have an 'impairment' bias, focusing on prevention of impairments and restoring functional ability in disabled individuals in order to 'fit' them into their community.

Changes in CBR over the last two decades

During the eighties and nineties there was tremendous growth in number of CBR programmes that were promoted in different developing countries, mainly by international donors. Many of these were micro projects with limited impact, that could not be replicated or grow into viable national programmes. Along with quantitative growth in CBR programmes, there were changes in the way it was conceptualised (Thomas & Thomas 1999). One of the early changes was the shift from a medical focus to a comprehensive approach, with the realisation that medical interventions alone did not complete the rehabilitation process. Thus CBR programmes also began to address comprehensive interventions such as education, vocational training, so-

cial rehabilitation and prevention. The other major change was a shift in focus from restoration of functional ability in an individual, to modifying community attitudes and contextual factors. The understanding was that it was not enough to merely change an individual to 'fit' him into the community, but that it was equally important to change contextual factors around the individual, as he/she does not live in isolation, but in the context of his/her own community. Along with this came the recognition that CBR also needs to include different issues related to disabled people's lives at all times, and not focus exclusively on rehabilitation. Changes in contextual factors involved changing attitudes of non-disabled persons in the community to accept people with disability and promote their inclusion, provision of equal opportunities in education, employment and so on, to the same extent that they were available to non-disabled persons. Alongside, protection of rights, and promoting community control and ownership of CBR programmes were also emphasised.

These changes during the last decade were reflected in various ways, at different levels, across different countries. The first was the change in definition of CBR, from a service delivery approach to a community development one, as reflected in the *Joint Position Paper* of WHO, ILO and UNESCO (ILO/WHO/UNESCO 2004). According to this definition, "Community Based Rehabilitation is a strategy within community development for rehabilitation, equalisation of opportunities and social integration of all people with disabilities. CBR is implemented through combined efforts of disabled people themselves, their families and communities, and with appropriate health education, vocational and social services". Many people accept this as a working definition. It moves away from the idea that CBR is merely a form of *therapy in community*, whereby services shift their geographical location to *the community*, but retain practices that are used in an institutional or clinical setting. In such community-based therapy, persons with disability and their families remain passive recipients of services, with professionals retaining control. The community development approach on the other hand, promotes community participation and community ownership of programmes, with the active involvement of persons with disability and their families in all issues of concern to them instead of being passive recipients. It also recognises that people with disability should have access to all services which are available to other people in community, such as community health services, child health programmes, social welfare and education.

Another reflection of these conceptual changes is the revision of ICIDH (WHO 2001). The *International Classification of Functioning Disability and Health* (ICF) avoids the term *disability* because of negative connotations and has replaced it with *activity*. *Handicap* is replaced by *participation* to indicate the person's nature and extent of involvement in life situations in relation to impairment, activity and contextual factors. *Contextual factors* are extrinsic factors that play an important role in determining participation. ICF covers three dimensions of functional state, namely, function and shape of body, activity and participation. Classification of function also includes mental functions. *Impairment* is a problem of function or shape of body. The second dimension is *limitation in activity* which reflects the difficulty an individual has in performing a task or an activity, formerly *disability*. There are qualifiers to indicate degree of difficulty and assistance required to overcome the difficulty. The third dimension is *restriction in participation*, formerly termed *handicap*. It exists when an individual has problems in participation in one of the life domains, due to either his impairment or because of environmental factors that commonly impact on participation. Unlike ICIDH, the emphasis has shifted from the individual alone to include the context around him. This classification is not linear and emphasises the simultaneous influences of the health condition and contextual factors on impairment, activity and participation.

The third significant change is promotion of equal opportunities and protection of rights of persons with disability by many governments in developing countries during the last decade. For example in South Asia, Sri Lanka, Bangladesh and India have enacted legislation to protect the rights of their disabled citizens.

Yet another reflection of these changes is the growth of organisations of persons with disability in many developing countries. Some of these countries have established national affiliates of the *Disabled Peoples International*, one of the major proponents of independent living movement from the West. These organisations have been active in all areas, including service provision, information dissemination and advocacy. Many have been instrumental in lobbying with governments to enact legislation to protect their rights and to bring about changes in existing laws to prevent discrimination against people with disability.

CBR today

The development of CBR can be seen as a progres-

sion from a *service provider-beneficiary* approach through a *service provider-client* one, which is now moving towards a client-owner emphasis. International policy statements now underscore the importance of rights and inclusion. Debates about *medical* and *social* models of disability have given way to a more universal understanding of the need for a comprehensive model. Today, the main goals of CBR have become broader, and focus beyond the individual, to his/her community where he/she is being integrated (Thomas & Thomas 2003). These goals are

1. To restore functional ability to the extent possible,
2. To create awareness to promote equal opportunities, barrier free environment and rights,
3. To create a situation in which the community of the person with disability participates fully and assimilates ownership of his/her inclusion into society.

Programmes and projects at various levels have formulated different strategies to achieve these goals. These include interventions for disabled individuals, for families and for the larger communities, utilising resources available within the communities to the extent possible.

There is greater emphasis now on information sharing and networking in the field, sometimes facilitated by donor agencies through their partner networks. More published literature is also available on CBR practice and results, in journals and newsletters. Many more training programmes are now available in different countries for different levels of CBR personnel.

Advocacy is actively promoted by different agencies, often through self-help groups of persons with disability or their families. In particular, self-help groups have become a significant tool to promote self-advocacy, inclusion, equal opportunities and rights.

Self-help groups in CBR

A *self-help group* is a voluntary association of people that functions democratically and accountably, to achieve the collective goals of the group (Ramachandran 2000a). Self-help groups are viewed as a means to achieve the newly emerging goals of inclusion and ownership in programmes by persons with disability, and to enhance their participation in the development process. Organising persons with disability or their families into self-help groups can serve different purposes depending on the situation and the need. Such a group can help improve their members' visibility in the community. The members can also support each other through discussions about common problems, share their resources and find solutions together.

The availability of an empathetic, supportive group helps persons with disability and their families to enhance their confidence and self esteem (Ramachandran 2000b). In addition, these groups can work towards their own economic upliftment.

Many difficulties are faced in the process of forming cohesive groups of persons with disability. In urban settings, particularly in the lower income sections, group formation can be particularly difficult (Thomas & Thomas 2001a). People who live in poorer sections of urban areas that exhibit many forms of social problems, do not easily trust each other. They often do not have a permanent address, do not easily form human bonding and show less concern for collective causes. The initial time taken for group formation in this context can be quite long. In rural areas, there are other problems such as distances between clients, and difficult terrain, that can make group formation less practical.

Another problem is the fear that a powerful few in the group will hijack the benefits from others (Thomas & Thomas 2001b). Persons with disability are usually a minority group in the community, hence their needs are often viewed as a low priority by the rest and they tend to get marginalised in a group. In order to prevent a few from hijacking the benefits of the group, especially economic activity, time needs to be given for the process of cohesive group formation before initiating such activities. Groups need considerable training and capacity building before they can function effectively and democratically. In such situations, an external facilitator helps to facilitate cohesive and democratic group formation and to carry out capacity building.

Lack of motivation on the part of persons with disability is another major barrier. Many persons with disability are not motivated to form groups to undertake their own development programmes. They expect grants rather than self generated economic development (Thomas & Thomas 2002). Service providers also prefer to give grants because they are easier to administer than economic development schemes, such as credit programmes. Counselling and motivating clients, their families and members of the community, either individually or in groups, helps to change attitudes that favour charity, to self-reliance and development.

Despite the challenges, self-help groups of persons with disability have been successfully organised in many countries. If it is feasible in the given context, group organisation has several advantages. It is used to initiate credit activity and group pressure could effectively be used to motivate clients to improve their

economic development. As a result of group formation, motivation to succeed also becomes greater. In some instances, groups take on the responsibility of monitoring some aspects of the programme. Participation from members of the community improves, as group members and their activities become more visible. Groups also function as a platform to create awareness on different issues and for purposes of advocacy. Working together as a group ensures better access to existing schemes and programmes. Group organisation for different purposes thus becomes a tool for overall empowerment of persons with disability.

Promoting inclusion through mainstreaming disability into development

At present, there are moves to promote disability as a crosscutting issue in all aspects of the development mainstream. This is becoming more evident in international statements relating poverty and disability. The *Joint Position Paper* of 2004 (ILO/WHO/UNESCO 2004) and the *Biwako Millennium Framework* (UNESCAP 2003) recommend poverty reduction as a key strategy in policies and services, including Community Based Rehabilitation, for persons with disability. This acknowledges the fact that poverty and disability can form a vicious circle, with poverty increasing disability and disability in turn resulting in increased poverty. Poverty is generally held to be a major cause of impairment and disability in developing countries, and many kinds of impairment are the result of specific diseases or conditions that are preventable. On the other hand, persons with disability are likely to become poorer because impairment or disability places heavy demands on limited resources, and reduces access opportunities for education or livelihood.

However, development programmes for poverty alleviation of governments and international agencies are yet to fully include persons with disability in their schemes. There are arguments *for* inclusion (that it reduces costs to persons with disability, families, community and governments) and *against* it (that disability is not a priority in poor communities, that it is a 'specialist' and expensive issue, that allocation of resources for prevention is more cost-effective). If disability is viewed from a human rights perspective, with the clear understanding that persons with disability have the same priorities and rights as everyone else in their community, the argument against their inclusion in the development mainstream may not be justified.

For development programmes to be more inclusive

and effective, they should consider integrating disability within the mainstream of their development policy and practice by identifying disability as a major cross-cutting issue. Mainstreaming disability into development would mean that all policies; programmes and projects would include disability as a key issue. This is particularly important when one considers that persons with disability are disproportionately represented among the poor, as shown by studies from different countries.

Conclusion

Community Based Rehabilitation evokes different perceptions in different people. Many view it as the only viable approach, to reach the majority of persons with disability in developing countries. Some opine that it is a strategy with ill defined boundaries. Despite the divergent views, there does not appear to be an alternative to CBR at present for the vast majority of people with disabilities in less developed countries.

The coming decades will be a phase of consolidation for CBR. As CBR expands from small to large programmes, research will become the key to develop new initiatives. Unlike in small programmes, sole reliance on past experience will be insufficient to initiate, maintain and achieve goals of large programmes. Hence great importance will be given to policy development, planning and monitoring in future. Good systems, efficient structures and tangible results will become preconditions for funding large projects. Pressures to follow internationally accepted good practice rules such as evidence based practices, would also become more prominent. On the whole, CBR will consolidate into a better defined, more accepted framework of development for persons with disability, within which wide contextual flexibility is permitted for each programme's structure and systems.

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Zusammenfassung: Die gemeindenahe Rehabilitation (Community Based Rehabilitation, CBR) kann als die bedeutendste Entwicklung der letzten 25 Jahre im Bereich der Rehabilitation von Menschen mit Behinderung in Entwicklungsländern angesehen werden. Ursprünglich war CBR eine Methode, den Zugang zu Diensten für Menschen mit Behinderungen in ländlichen Regionen zu verbessern. Seitdem ist das Modell sowohl konzeptionell als auch in der Praxis vielfältigen Veränderungen unterzogen worden. Der Artikel beschreibt die Entwicklung der gemeindenahen Rehabilitation von einem Dienstleistungsansatz zu einer Strategie für Inklusion und Förderung der Menschenrechte.

Résumé: La Réadaptation à Base Communautaire (RBC) peut être considérée comme le développement le plus important des 25 dernières années dans le domaine de la réadaptation des personnes handicapées dans les pays en développement. A l'origine, la RBC était une méthode pour améliorer l'accès des personnes handicapées aux services dans les régions rurales. Depuis, le modèle a subi de nombreux changements, tant conceptionnels que pratiques. L'article décrit le développement de la RBC d'une offre de services vers une stratégie pour l'inclusion et la promotion des Droits de l'Homme.

Resumen: La Rehabilitación en Base a la Comunidad (RBC) es el desarrollo más importante de los últimos 25 años en el area de rehabilitación de Personas con Discapacidad. Principalmente RBC fue un método para mejorar el acceso a servicios rehabilitativos en zonas rurales, pero con los años recibió varios cambios conceptuales y prácticos. El artículo describe este cambio en el desarrollo de la RBC, empezando como enfoque para mejorar el servicio para Personas con Discapacidad hacia una estrategia para la inclusión y la promoción de los derechos humanos.

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The Role of Disabled People's Organisations in the Development of Community Based Rehabilitation in Quang Tri Province, Vietnam

Vu Thi Bich Hanh/Nguyen Thi Thuy Hanh/Anneke Maarse

This is the first qualitative study dealing with the role of *Disabled People's Organizations* (DPOs) in the development of *Community Based Rehabilitation* (CBR) in Vietnam. The findings from the study show that DPOs play an important role and highly contribute to the effectiveness of CBR activities especially by enhancing the process of community integration of *persons with disabilities* (PWDs). Based on these findings the researchers recommend that DPOs' participation in CBR should be facilitated by the government as well as by the community.

Introduction

Vietnam is a developing country in the Asian-Pacific region, with a population of 82 million inhabitants. According to data of the Ministry of Health (MoH) from 6 provinces the disability prevalence in the total population is approximately 3,4%. CBR is being implemented in Vietnam since 1987, and at present (2004) CBR has been implemented in 46/64 provinces and covers more than 20% of the districts and communes in the whole country (Pengjian 2004). A special characteristic of CBR in Vietnam is that it is integrated in the extensive health network that is established at all levels from village to national level. Through CBR a large number of *persons with disabilities* (PWDs) including *children with disabilities* (CWD) have been receiving rehabilitation services and support in the field of income generation and education. Over time legislation on support for PWD has also been developed, such as: the *Ordinance on Disabled People* promulgated by the National Assembly in 1998 and other decrees, policies and legal documents issued by different Ministries. In 2003 a decree (No 88/2003 ND-CP) was promulgated by the government guiding the establishment of civil organizations, including the *Disabled People's Organizations* (DPOs). Based on this documentation a legal corridor for the activities of PWDs has been created, facilitating PWDs to establish their own organizations, to protect their rights and to raise their voice on behalf of PWDs.

The objectives of the study

In order to collect experiences and lessons learnt on the potential role of DPOs in CBR development a study was conducted on international and national experience. This study was conducted by researchers from Hanoi Medical University and supported by Medical Committee Netherlands Vietnam.

The objectives of this study were:

1. To investigate the policies and approaches to encourage the participation of PWDs and their organizations in the CBR programme in Quang Tri Province.
2. To explore the role and potential of DPOs and the mutual relationship between DPOs and the CBR programme to develop the programme.
3. To describe the role of individuals and organizations in enhancing and mobilizing the participation of PWDs and DPOs in CBR as well as experiences and potential of the activities of DPOs.
4. To investigate experiences in enhancing participation of PWDs and DPOs in CBR programmes in countries in the Asia-Pacific region.
5. To formulate recommendations in promoting the role of PWDs in implementing and developing CBR in Vietnam by incorporating and analyzing the experiences of Vietnam and other countries.

Research methods

Qualitative research methods were applied in this study with the techniques such as in-depth interviews and focus group discussions. Making use of Venn diagram was done during the time of focus group discussion to investigate the role of organizations and individuals in supporting CBR programmes. Besides, a desk study has been conducted to collect international experience on the role of DPO's in CBR development.

The study has been conducted in Quang Tri town and Vinh Tu commune in Quang Tri Province. These study sites were selected because of the strong involvement of DPOs in the CBR activities in these localities. To receive additional ideas from PWD, several DPOs have been interviewed in Hanoi city, even though they were not involved in CBR activities at the moment of the interviews.

In Quang Tri, a total of 12 PWDs (members and non members of DPOs), CBR Steering Committee

members, and 4 CBR supervisors were interviewed. Four focus group discussions were conducted with PWDs (either members of DPOs or not), family members of PWDs or their neighbors. In Ha No, a Ministry Official, 4 representatives of DPOs and a representative of an International NGO were interviewed, and focus group discussions were done with members of DPOs.

Information collection focused on the barriers of PWDs in the social integration, information about DPOs and its principal activities, as well as its role in CBR development. Further questions were asked about the supports from the CBR programmes to DPOs activities and how PWD experienced the role of other individuals and institutions in their support. Besides, each respondent was asked for suggestions and recommendations regarding PWD/DPOs participation in CBR activities.

Main findings

The results of the study have shown clearly the DPOs' important role and significant contribution to CBR development. The study describes the following aspects of the mutual relationship between the CBR programme and DPOs:

Health care and home-based rehabilitation for PWD

Together with the Community Healthcare Board of the commune the DPO of the commune is involved in preparing rehabilitation plans for their members. This board meets once every month and a representative of the DPO is invited to this meeting. In this meeting, also CBR activities are discussed. The DPO is responsible to encourage its members to participate in CBR and help each other in the rehabilitation process.

Economic development for their members

Representatives of the members of the Disability Club of Ward 1 and the Association of PWDs in Vinh Tu Commune have contacted national and international organizations to look for credit opportunities. This would have been more difficult if each member had to do this individually. Usually, to have access to credit, one must have some collateral or an organization as a guarantor. Since most of the families of PWDs are poor, it is vital for them to have the DPO as a guarantor organization to have access to capital sources. The DPO in Vinh Tu Commune was established in 2000 and since then, most of its members have participated in some economic projects or received credit. They already implemented 15 produc-

tion projects. Although the Disability Club of Ward 1 has operated for only 2 months, it has 3 production, animal breeding and service projects waiting for approval.

Enhancing access to information and training opportunities for PWDs

Through the DPO meetings PWDs know more about the situation of other PWDs and DPOs in other provinces. Besides, its representatives attend the communal meetings of different mass organizations, as well as meetings of DPOs in other communes. The study also describes examples of PWD that have attended (vocational) training courses through intervention of the DPO. The importance of training and other capacity building activities for PWD is acknowledged by Mr. Tran Dinh Khoanh, Chairman of Vinh Tu Commune People's Committee, who said: "To have PWDs in certain positions, we should give them the opportunity to show their ability. For example, if PWDs want to have a seat in the Commune's People's Council, they should be excellent in their business and be trusted, in order to get votes from the people."

Sport and culture activities

The DPO also organizes for its members to attend provincial and national sports competitions for PWDs. The PWDs receive an allowance for traveling, food and accommodation. One of their members has won a bronze medal at a swimming competition of the province. Once a year, the commune organizes a camping holiday for the members of the DPO.

Mutual support and sharing

Before becoming a member of the DPO, PWDs did not go out of their house and had no friends. Their families are busy working and have little time to share with them. Being members of the DPO, PWDs can meet and talk, encourage each other and make friends. They have a common place to share, which they can rely on when there are difficulties.

Supporting PWDs to build up their confidence to integrate in the society

Through positive role models, the members of the DPO become more self-reliant and self-confident to overcome their difficulties. The important thing that the members learn when participating in the activities of the DPO is that they are not a charity object. They just need an opportunity to show their ability just like all other people. This important change in awareness of the PWDs is achieved through specific activities like "providing information on PWDs who are suc-

cessful in business, art and sports events through newspapers, meetings or mass media. Further, every month, the DPO receives the updated information from the Disability Forum by post. Besides, the DPO sends its representatives on exposure visits, vocational training and other training courses. Its representatives are also invited to the monthly meetings of the Community Healthcare Board. Therefore, they are informed on the CBR activities in the commune regularly" (Mr. Le Huu Bang, Vice Director of Vinh Tu Association of PWDs).

Improving the status of PWDs in the community

Because the DPO removed the barrier between PWD and the local government, the awareness of the local authorities has changed. Before the establishment of the DPO, the government did not understand about the abilities of PWDs. The accomplishments of the DPO have confirmed the position of PWDs, enhancing their self-confidence and their status in the community. PWDs participating in other social organizations and holding certain positions in the commune's mechanism makes them respected and trusted. The accountant of the commune People's Committee and the chief accountant of My Tu Cooperation are PWDs which gives them more opportunity to communicate with the individuals and organizations in the community.

Besides conducting CBR activities similar to other locations, the steering committee of the commune also has a consultative and supportive role in the establishment of a DPO. Thanks to the CBR workers, PWDs get to know each other and have information on the training activities and the progress of other PWDs in the village. They act as a catalyst in linking individuals to form a group. They encourage PWDs to meet and exchange their experiences. According to Ms Nguyen Thi Hoa, a nurse in the medical center of Ward 1 and member of the Community Primary Healthcare board, the support for the establishment of a DPO includes:

- Linking individual PWDs to form a group of PWDs
- Assisting and advising the group on procedures to establish a DPO
- Providing information and guideline documents
- Helping the group to select key persons to be the leaders of the DPO
- Advising the DPO in composing the statutes and objectives of the DPO

In summary, the close relationship between DPOs and the CBR programme starts naturally from their common objectives, being the promotion of equal par-

ticipation of PWDs. Like the experience of Mauritania, Mali and Senegal (Camara 1998): "Although there are differences in the nature and strategies, DPOs and CBR have similar objectives: equal chances and social integration for PWDs. Therefore, they should cooperate and commit to be active partners."

Conclusions

- To raise awareness on the abilities of PWD in the community as a whole including PWDs themselves DPOs play a very important role. As the members of these organizations, PWDs can raise their voice and consolidate their position in the community.
- Through DPOs, PWD can play a more active role in the CBR programme. Instead of being just the beneficiaries of the rehabilitation service, they can now also become partners, active participants and managers of the programme. The DPO will help them in their lobby for support; through the DPO the rights and opinions of PWDs are paid much more attention to.
- DPOs can act as a bridge between PWDs and the society and play a vital role for PWDs by offering those places where they feel equal to others, where they can share and learn.
- Members of DPOs acknowledge the significant role of CBR in assisting and consulting DPOs and their members regarding their rehabilitation process as well as on how to set up and maintain activities of a DPO.
- Families, mass organizations and unions are also mentioned as playing an active role in assisting PWDs and DPOs in their social integration. Thanks to the DPOs' role as the bridge, individuals and organizations in the community can provide more support to PWDs.

Recommendations

From the study results and the experiences in CBR of other countries in the region, several recommendations were formulated such as:

For national level

- PWDs and their representing organizations should be involved in the development of socio-economic policies that relate to PWDs, developing CBR into a national target programme.
- Specific guidance on procedures to establish DPOs is needed, explaining in detail all the steps in the procedure of DPO establishment. Groups of PWDs may need an advisor on the procedure.

For local government (province, district, commune)

- The policies of the central authorities should be implemented at local level aiming at equal participation of PWDs in all socio-economic activities and in CBR programmes in every phase and at the highest level.
- Capacity building activities should be conducted for PWDs/DPOs to develop their abilities and enhance their participation in decision making processes.
- DPOs should be represented in the local CBR Steering Committees. The existence of a DPO should be a pre-condition for starting a CBR programme in a locality.
- The involvement of DPOs in CBR should start in the early stage of development of the programme and they should be involved in every phase of the programme cycle.
- DPOs should be involved in all activities of the CBR programme, including training. To be able to do so the capacity of PWDs/DPOs needs to be built to develop their knowledge and skills to undertake different tasks in the CBR programme.

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Zusammenfassung: Der Artikel ist die erste qualitative Studie zur Rolle von Behindertenorganisationen (Disabled People's Organisations, DPOs) in der Entwicklung der gemeindenahen Rehabilitation (Community Based Rehabilitation, CBR) in Vietnam. Die Ergebnisse der Studie zeigen, dass DPOs in hohem Maße zur Effektivität von CBR-Projekten beitragen, insbesondere dadurch, dass sie den Prozess der Integration von Menschen mit Behinderungen in die Gemeinschaft vorantreiben. Ausgehend von diesen Ergebnissen empfehlen die Verfasser, DPOs die Teilnahme an CBR-Projekten zu ermöglichen.

Résumé: Cet article est la première étude qualitative sur le rôle des organisations de personnes handicapées (OPH) dans le développement de la Réadaptation à Base Communautaire (RBC) au Vietnam. Les résultats de l'étude montrent que les OPH contribuent grandement à l'efficacité des projets de RBC, en particulier en ce qu'elles promeuvent le processus d'intégration des personnes handicapées dans la communauté. Sur base de ces constats, les auteurs recommandent de renforcer la participation des OPH dans les projets de RBC.

Resumen: El artículo presenta la primera investigación cualitativa sobre el rol que tienen las Organizaciones de Personas con Discapacidad (OPD) dentro del desarrollo de la Rehabilitación en Base a la Comunidad (RBC) en Vietnam. Los resultados enseñan que las OPD tienen una gran influencia a la eficacia de los proyectos comunitarios, especialmente porque impulsan a la integración de las Personas con Discapacidad en la comunidad. En base a estos resultados los autores recomiendan la participación de las OPD en los programas de la RBC.

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Sozialmedizinische Einseitigkeiten indischer Sonderpädagogik

Thomas Friedrich

Vorliegender Aufsatz bemüht sich, das deskriptive Fundament von E. Wilken/U. Wilken zur indischen Heilpädagogik aus dem *Handbuch Vergleichende Sonderpädagogik* (1987) fortzuschreiben. Das außereuropäische Diskursfeld vermag fundamental die Komplexität des eigenen Faches zu zeigen und beweist die nötige Dynamik von Sonderpädagogik, die je nach ihrem Standort in einer je differenten Soziokultur kontextuiert ist und daher ein responsables Antlitz aufweist, d.h. auf die Situation von Behinderung vor Ort antwortet.

Abbild der rehabilitativen Idee

Anders als in Deutschland war für Indien das Internationale *UN-Jahr der Behinderten* 1981 der wichtige Anlass zu einer kritischen Bilanz, die sich in den beiden Publikationen von Gajendragadkar (1983) und Culshaw (1983), später fortgesetzt von Pandey/Advani (1997), niedergeschlagen hat. Die Anregungen dieses UNO-Jahres, korrespondiert von der weithin bekannten WHO-Initiative 1980 zur Einführung einer CBR (*Community Based Rehabilitation*) statt der lange Zeit vorherrschenden IBR (*Institution Based Rehabilitation*) hatte in Indien einen Aufbruch und eine erneuerte Bewegung der sonderpädagogischen Gestalt zur Folge. Der Anfang der heutigen Sonderpädagogik Indiens war gemeinhin gegen Ende des 19. Jh. zu suchen, als einige wenige christliche Missionare, betroffene Eltern oder vermögende Philanthropen die Initiative ergriffen hatten und ausgewählte Institutionen schufen. Der Staat in Form der britischen Kolonialregierung hatte kein Interesse am Aufbau einer Sonderpädagogik oder einer Behindertenfürsorge; entsprechend der Kolonialökonomie wurde dann investiert, sobald entweder Erträge zu erhoffen oder ein Bedarf der Administration und des Handels zu decken waren. So verblieb die Sonderpädagogik bei privaten und kirchlichen Trägern, erst nach der Unabhängigkeit 1947 bekannte sich die neue Regierung Nehru im Verfassungsartikel 41 zu einer staatlichen Verantwortung, d.h. zu einer umfassenden Verpflichtung für die Gewähr einer Behindertenfürsorge. Gleichwohl ist die

Sonderpädagogik auf nicht staatliche Unterstützung weiter angewiesen geblieben; nach Wilken/Wilken (1987, 689) seien um 1980 nur 20 % der indischen Einrichtungen in staatlicher Hand gelegen.

Zwar wird aus vorkolonialer Zeit von einer elementaren Versorgung beschädigter, kranker und verarmter Personen an den Tempeln und Pilgerstätten, auch in den Gemeinden gesprochen (Pflug 1974/75, 250) – Miles (2003, 99) findet in der Sanskrit- und Pali-Literatur auch Mitteilungen über Renten und Tagesbeihilfen an den hinduistischen Königshöfen –, aber diese Grundversorgung mit Essen, Kleidung und Unterkunft blieb karitativ, hatte keinen edukativen Hintergrund. Culshaw (1983, 17) erwähnt die mildtätigen Einrichtungen und Hospitäler, die Kaiser Ashoka (273-232 v.Chr.) entlang der Handelsstraßen das Maurya-Reich durchziehend hatte errichten lassen. Noch um 400 n.Chr. habe der chinesische Pilger Fa Hsien von diesen und weiteren wohltätigen Anstalten in Indien berichtet, habe dabei von einer Hilfe zur "Reparatur" Mittelloser, Verkrüppelter und Kranker erzählt.

Ich sehe darin frühe Ansätze einer sich ausbreitenden Rehabilitation von beeinträchtigten Menschen, die nach dem historischen Bruch durch die muslimischen Eroberungen seit dem 11. Jh. und der europäischen Expansion ab dem 16. Jh. erst unter dem britischen *Empire* in ihrer Bedeutung deutlich wiederbelebt worden sind. Insbesondere in der zweiten Hälfte des 19. Jh. sind die Nöte und die Situationen von Menschen mit Behinderung wieder ins öffentliche Bewusstsein eingedrungen. Ein rehabilitativer Anspruch war aber

anfänglich schlicht gedacht und primär versucht als eine Versorgung und Erhaltung beschädigter Menschen, die Prämisse implizit bereits mitschwebend und durchtragend, ihr Klientel als problematische Individuen mit Anpassungsbedarf zu werten. Im Vordergrund stehen seitdem in Indien bis weit über das Unabhängigkeitsdatum 1947 hinaus der Modus der Behandlung und nach europäischem Vorbild die defizitorientierte Klassifizierung von Menschen. Ambition war der Aufbau von umfassenden Institutionen für den Einsatz von Spezialisten: z.B. 1886 die Blindeneinrichtung in Amritsar, gegründet von der Missionarin Sharp, später ins Bergland nach Dehra Dun verlegt, 1943 für Kriegsblinde benutzt und nach 1950 von der Regierung zum Modellzentrum mit Braille-Druckerei und Blindenbücherei ausgebaut. Der Erziehungsaspekt während jener schrittweisen Installation einer möglichst breit Schädigungssparten erfassenden IBR geriet hierbei lediglich zum Bestandteil der überlagernden medizinischen Priorität, zunehmend mit Wiederherstellungsanspruch einer Funktionabilität und Utilität nicht intakter Personen konzipiert: kurative, späterhin auch präventive Bemühungen bestimmen das Geschehen, weniger aber edukative.

Die maßgeblichen Daten des institutionellen Wachstums sind andernorts zusammengestellt (vgl. Friedrich 2002, 309-311, Wilken/Wilken 1987, 689-698). Dennoch lohnt die auffallende Vorkämpferrolle der Gehörlosen- und Blindenpädagogik erwähnt zu werden, die ähnlich zu Europa auch in Indien die voraneilenden Zweige der Sonderpädagogik gewesen sind. Auffallend ebenso die dazu konträr späte Entwicklung einer Pädagogik zur Geistigbehinderung erst im Verlauf des 20. Jh.: so z.B. der Hinweis von Miles (1997, 25) auf das *Children's House* der Silvia de la Place, dokumentiert für 1918 in Kurseong nahe Darjeeling als eine erste Sonderschule für körperlich und kognitiv beeinträchtigte Kinder, oder jener von Machiwalla (1983, 99) auf frühestbekannte Geistigbehinderteneinrichtungen in Ranchi 1934 und in Bombay 1941. „To live a normal life span“ (Prabhu 1983, 5) - mit dem UN-Jahr 1981 gedenkt eine Rehabilitation in zwischen der Kulturtechniken, der beruflichen Teilhabe und einer aktivierenden Perspektivbildung.

Trotz aller Umtriebigkeit privater und nicht staatlicher, elterlicher oder missionarischer Initiative, welche sogar international anerkannte Diagnose- und Förderzentren generierte, kritisieren Wilken/Wilken (1987, 689) die unüberschaubaren, nahezu wildwüchsigen Ausprägungen der Behindertenhilfe, insonderheit die unkoordinierte westliche, und eine indische Bedarfsdeckung von gerade einmal 2 % seitens der bestehenden IBR. Diese magere Rate wird auch ein

Jahrzehnt später von R.S. Pandey und Lal Advani bestätigt.

Quantitäten

Gajendragadkar (1983) bezieht, für den europäischen Horizont ungewohnt, Krebs, Arthritis und Altersdefizienzen ausdrücklich in das sonderpädagogische Feld mit ein. Dagegen erscheint die Problematik der Lern- und Verhaltensbehinderung, die in Europa einen hohen Anteil ausmacht, in Indien als unbeachtet. Vielmehr zeigt die Wechselwirkung der Armut ihre Dominanz, was sich in Kinderarbeit, Schulabbrüchen, Schuldknechtschaft, Obdachlosigkeit, Verwahrlosung, Mangel-/Fehlernährung und Infektionen ausdrückt. Wilken/Wilken (1987, 689) schätzen 90-95 % aller Personen mit Behinderung den unteren sozioökonomischen Schichten zugehörig. Behinderung erfährt somit schnell einen sozial inferioren Status, Armut bedeutet physische und psychische Verelendung.

Evident zeigt sich die immanente Unstimmigkeit der empirischen Daten zu Häufigkeiten; die Zahlen beruhen meist auf Schätzungen oder Hochrechnungen, wenig auf fundierten und tatsächlichen Zählungen. Vor 1981 sind gezielte Daten zu Behinderungen in den Volkszählungen nicht erhoben worden, allein der *National Sample Survey* (NSSO) von 1981 war ein erster, aber die Stadt-Land-Disparitäten verzerrender Versuch. Vorhandene Statistiken weichen teils erheblich voneinander ab, die Zahlen können daher nur vorsichtig eher als Näherungswerte gelten. Die Volkszählung 2001 (*Census of India 2001*) beansprucht eine exaktere Abklärung, doch sind Resultate auch noch drei Jahre danach nicht zu bekommen. Fragwürdig ist überdies die kategoriale Zuordnung der Daten und die definitorische Abgrenzung unter den oben aufgezählten bezogen auf die verschiedenen Arten von Beeinträchtigungen. Hier eine Aufstellung akzeptierter Zahlen, die beiden ersten Spalten auf der Bevölkerungsbasis von 1981 (683,3 Mio), die dritte auf der von 1991 (846,3 Mio) erstellt.

Eine Besonderheit: zur Häufigkeit einer Geistigbehinderung gibt es bislang keine einzige landesweit fundierte Erhebung. Oft wird auf lokale Zählungen zurückgegriffen, so auf jene 1968 in Nagpur/Maharashtra mit 3 %, 1970 in Lucknow/Uttar Pradesh mit 2,33 % oder 1979 im Poona District/Maharashtra mit 3,14 % (Pandey/Advani 1997, 27). Lokale Variablen erhalten, herangezogen zu Hochrechnungen auf nationale Ebene, ungeahnte Billigung.

Ein neuerer Bericht der indischen Bundesregierung, der *National Human Development Report 2001* auf der Basis des fortlaufenden *National Sample Sur-*

	nach Gajendragadkar (1983, IX)	nach Culshaw (1983, 25)	nach Pandey/Advani (1997, 17 ff.)
Körperbh.	4,2 Mio (0,61 %)	5,6 Mio (0,82 %)	8,94 Mio (1,06 %)
Lepra	3,2 Mio (0,47 %)		1,68 Mio (0,2 %)
Hörbh.		3 Mio taub (0,44 %)	3,24 Mio (0,38 %)
Sprachbh.			1,97 Mio (0,23 %)
Geistighb.	18 Mio (2,63 %)	18 Mio (2,63 %)	2,33 bis 3 % der Bev.
Sehbh.	9,5 Mio (1,39 %)	9 Mio blind (1,32 %)	4,01 Mio (0,47 %)
Altersbh.	28,8 Mio (4,21 %)		
Zerebralparese		2 Mio (0,29 %)	
Psychiatr.Bed.		11 Mio (1,61 %)	
Elephantiasis		14 Mio (2,05 %)	
Tbc		2 %	
Mehrfachbh.			12,3 % aller Bh.
Schwerbh.			25 % aller Bh. Land 20 % aller Bh. Stadt

Tabelle1: Menschen mit Behinderungen in Indien

vey (NSSO), bietet einen überraschenden Behinderungsanteil von nur 1,9 % aus der 1991er Population (Planning Commission 2001, 101) – immerhin eine gravierende Abweichung vom WHO-Richtwert einer weltweiten Behinderungsverteilung von etwa 10 %. Die NSSO-Erhebung hatte die Sinnesbeeinträchtigungen und lokomotorischen Schädigungen zu ihrem Behinderungsbegriff ordiniert, dabei Geistigbehinderung oder Zerebralparese nicht thematisiert (Planning Commission 2001, 101).

Überraschend ebenso die recht hohe Quote ruraler Gebiete, die 78 % aller Behinderungen bei sich wiederfinden, während die gängige IBR nahezu vollständig urbanisiert ist. D.h. in den Hochbedarfsregionen ist der Versorgungsgrad ausgesprochen niedrig.

Fachliche Absenzen

Sonderpädagogik ist personalintensiv. Eine *vertiefte* Erziehung (Paul Moor) hat gewichtig mit Personen zu tun und existiert vornehmlich in einem Beziehungsgefüge. Die Personen untereinander kreieren tätig ihre individuelle Erziehungsgestalt, motivierte Pädagogen sind *Alpha und Omega*, Dreh- und Angelpunkt für ihre Kinder. Nichtsdestoweniger mangelt es jener in Indien an ausgebildeten Fachkräften, die zudem auch noch bereit sind, in den Dörfern tätig zu werden. Auch die vielen verschiedenen Ausbildungspläne und -inhalte weichen stark voneinander ab. Daher unternimmt der *Rehabilitation Council of India* (RCI) seit seiner staatlichen Einsetzung 1986 eine landesweite Standardisierung der Ausbildungskurse und eine Registrierung anerkannter Lehrstätten und Fach-

personals. In ihrer Liste sind bislang 131 Institutionen und 49 Studiengänge aufgenommen, die je nach Dauer und Intensität staatlich anerkannte Zertifikate, Diplome, Bachelor- und Master-Grade vergeben dürfen. 1992 hat der RCI nach sechsjähriger Bewährung seine gesetzliche Legitimation erhalten; mit seiner Koordinationsbefugnis entscheidet er letztlich über die Zulassung von Helfern mit der beachtlichen Folge von Mittelzuweisungen mit.

Für ein Zertifikat reichen schon Aufbaukurse von einem Monat bis knapp über

ein Jahr, meist jedoch sechs Monate, aus. Diplom- und Bachelor-Studienkurse beanspruchen meist ein bis über zwei Jahre, Master-Kurse oft drei Jahre. Auch drei- bzw. fünfjährige Studiengänge in *Integrated Rehabilitation and Special Education* werden in den Instituten für Verhaltenswissenschaft an den Universitäten Kottayam und Coimbatore angeboten. Bemüht war die Regierung um den Aufbau von inzwischen sechs Nationalinstituten zur Forschung, Ausbildung, Praxistentwürfen und operativen Eingriffen: zur Körperbehinderung 1976 in New Delhi (*physically*) und 1982 in Calcutta (*orthopaedically*), zur Sehbehinderung 1979 in Dehra Dun, zur Hörbehinderung 1983 in Bombay, zur Geistigbehinderung 1984 in Secunderabad und zur Rehabilitationsforschung 1984 in Olatpur. Immer noch ist der Ausbildungsbedarf weit höher als die Jahresabsolventenzahl der Kurse (vgl. NIC 2000).

Miniatur Mensch

Dieser bloße Umriss an Daten, so nüchtern er für Leser vorerst ist, skizziert doch recht gut das Primat der besagten IBR innerhalb der indischen Sonderpädagogik. Signifikant ist die Konzentration auf Großstädte; die knappen Finanzressourcen werden für repräsentable Modelleinrichtungen verbraucht. Die Majorität der Bevölkerung findet aber kaum Zugang zu solcher modernen Ausstattung, die relativ raren Plätze suggerieren eine Privilegiertheit der Inhaber. Wilken/Wilken kritisieren denn auch eine "Tendenz zu totalen Versorgungsstrukturen" in "ghettoähnlichen Mammutzentren" (1987, 698). Der behinderte Mensch – ich wähle die Metapher einer feinstimmigen Miniatur –,

in seiner erschwerten Begabung und mitschwingend in seiner hilflosen Mitwelt, entfalle jedoch diesem rehabilitativ-technischen Blick. In Anlehnung an Emil Kobis Differenzierung möchte ich daher die indische Sonderpädagogik in ihrer vorherrschenden Ausprägung dem "medizinischen Modell" zurechnen. Unter dem Dach der Medizin geschieht solchermassen eine Erziehungsdynamik, die geleitet wird von der institutionellen Gewichtung auf die Schädigung (*impairment*) des Edukanden. Unfähigkeiten, Versagen, Devianzen betonen konsekutiv Dynamik und Klang dessen personalen Selbstbildes; sein Menschsein ist reduktiv mit Unvollständigkeit identifiziert.

Eine Modifikation dieses Modells wird seit 1985 mit der WHO-Handreichte zur CBR realisiert. Der Perspektivwechsel von der urbanen IBR zur ruralen Gemeinwesenarbeit ist damit langsam erfolgt. M. Thomas schreibt knapp von „the shift from everything for a few to something for everyone, along with the provision of services for a majority of the population within a reasonable period of time and in a form acceptable to them“ (1992, 404). Im Zuge eines endlich landesweit durchsetzbaren (bereits lange benötigten) Ausbaus der Basisgesundheitsdienste geschieht eine sozialmedizinische Rehabilitation und auch Gesundheitserziehung in den Dörfern vor Ort mithilfe lokaler *Primary Health Centers* (PHC), bislang elf regionaler *District Rehabilitation Centers* (DRC) und vier überregionaler *Regional Rehabilitation and Training Centers* (RRTC). Mental vorbereitet zeigt sich die CBR von der seit 1952 zumindest angelegten, wenn auch zögerlich umgesetzten Regionalplanung namens *Community Development Programme* (CDP) – einer intersektoralen Entwicklung des ländlichen Raumes auf den drei Pfeilern der Erziehungsförderung, der Gemeindeselbsthilfe und der Regierungsunterstützung – und profitiert von der seitdem angestoßenen Einführung eines Grundgerüsts aus PHC (vgl. Diesfeld 1995, 362). Eingesetzt sind nunmehr in den Dörfern auch rudimentär geschulte *Village Health Workers* (VHW), die Hilfestellung durch das Fachpersonal der PHC, der DRC und der Hospitäler erhalten und dorthin Dorfbewohner für schwierigere Behandlungen auch überweisen können. Die WHO-Handreichte ist für die Dorfhelfer und die Familien erstellt, die daraus in vereinfachter Weise nützliche Praxishinweise erhalten. Die Fachleute in den RRTC übernehmen Ausbildungsaufgaben, die in den DRC Koordinationsaufgaben und spezielle (auch teurere) therapeutische Eingriffe (vgl. Thomas 1992, 404).

Obwohl über CBR eine Bewusstseinsarbeit in den Gemeinden zum Kontext von Behinderung geleistet wird und die Dörfler zu einer aktiven Teilnahme an ei-

ner Behindertenhilfe aufgefordert sind, bleibt auch dieser verbesserte Ansatz dem medizinischen Modell verpflichtet. Eine Evaluation von 1989 hat der CBR zwar eine gute Bedarfsdeckung von 71 % in medizinischen Belangen (Operationen, Physiotherapie, Mobilitätstraining, apparative Hilfen) bescheinigt, ihr aber gravierende Misserfolge im Bereich von Schule und Ausbildung nachgewiesen. CBR sollte aber gleicherweise den medizinischen, den schulischen und den beruflichen Sektor umfassen. Wie jeder andere Erziehungsversuch ist auch die CBR den allgemeinen hinderlichen Sozialbedingungen aus Armut und Mangelversorgung unterworfen. Der erwartete Anstoß zu einem Ausbau des Beschulungsangebots und zu einer Mobilisierung Freiwilliger ist bisher fehlgegangen. Kaum erreichen können aber hat sie die Gruppen der geistig behinderten und der sehgeschädigten Personen (Pandey/Advani 1997, 126-127).

Abseits dieser medizinischen Dominanz und als Supplement zum CBR-Programm ist seit 1987 (revidiert 1992) in bislang zehn ausgewählten Landkreisen (*blocks*) mit dem Integrationsprogramm PIED (*Project Integration Education of Disabled*) begonnen worden. Alle Regelschulen des ausgewählten *blocks* sind aufgefordert worden, zusätzlich Kinder mit Behinderungen aufzunehmen, die zuvor keinen Zugang hatten. Zu diesem Zweck haben alle *primary teachers* für eine Woche eine Fortbildung zum Phänomen Behinderung erhalten und etwa 30-40 % dieser Lehrer für weitere sechs Wochen eine Zusatzschulung für den unterrichtlichen und didaktischen Umgang mit Behinderung erfahren. In einjährigen Kursen wurden einige dieser vorgeschulten Personen überdies zu *resource teachers* ausgebildet, die nunmehr als mobile Lehrkräfte für ein Bündel von Schulen (*cluster*) eingesetzt sind. Hier zeigt eine erste Evaluation von 1995 beachtliche Erfolge: einen Anstieg der Einschulungsquoten vor allem körperlich beeinträchtigter Kinder, eine bemerkenswert niedrige Abbrecherquote (unter 6 %), eine gestiegene pädagogische Kompetenz und Sensibilität der Lehrkräfte und eine gestiegene Akzeptanz durch die Eltern. Erreicht hat PIED allerdings wieder nicht die Kinder mit geistiger Behinderung, kaum auch die Mädchen (Pandey/Advani 1997, 85-91). Weiterhin sind Kinder aufgrund ihrer *conditio humana* aus Schule und Erziehung ausgeklammert.

PIED sucht die Grenze schulischer und dadurch gesellschaftlicher Integration zu öffnen, durchlässig zu machen, und erreicht doch nur eine leichte Verschiebung dieser Grenze, die eine *conditio educativa* kennzeichnet: diesseits von ihr kann die *conditio humana* bestimmter ausgewiesener Kinder ‚erleichternd‘ mit schulischen Mitteln beantwortet werden, jenseits von

ihr verbleiben die anderen Kinder in ihren erschwerenden, ‚unmöglichen‘ Bedingungen und harren dem Tag, ohne Wissen und ohne Entscheidung um ihre Möglichkeiten.

Dissonanzen

Die indische Gesellschaft birst vor Verwerfungen, Umbrüchen, Kollisionen und Übergriffen. Neben dem friedvollen Respekt vor den Vielfältigkeiten indischer Lebensweisen, -welten, -entwürfen und -entscheidungen stehen die erodierende Toleranz, aufeinanderprallendes Denken und Agitation, auch gedemütigtes Leiden. Die Sonderpädagogik ist nichtsdestotrotz diesen innergesellschaftlichen Konflikten unterworfen: die traditionellen einheimischen Wahrnehmungen von Behinderung inmitten der Pluralität hinduistischer, buddhistischer, islamischer, jaina- (usw.) Deutungsmuster und Wirklichkeiten kollidieren mit dem okzidental importierten Helfersystem mit seiner eindeutigen Definitionsgewalt der WHO, sei dieses nun IBR- oder mehr CBR-orientiert. Die Behinderungsidee bewegt sich in der traditionellen Deutung in dem weiten Spektrum der Aussage zwischen "kein Mensch sei behindert" und "jeder Mensch sei behindert": erstere Haltung begründet mit dem *atman*, den jedes Lebewesen habe, insbesondere jeder Mensch, welcher damit als ein *pars pro toto* der universalen Transzendenz existiere, in seiner gewollten und mitgegebenen Eigenart oder Differenz einer Selbstberechtigung aufliege; die zweite Aussage begründet darin, dass alle Menschen in ihrem Erdendasein des Heils noch bedürfen, alle auf *moksha* ausgerichtet seien und in ihrer Weltanhaftung allda und allesamt ungenügend, unzureichend, unvollendet, schlicht defizitär und unrein seien. *Moksha* meint den Ablösungsgedanken aus dem Leidenszyklus der Existenz, aus der harten Vergeltungskausalität (*karma*) im Tun und Nichttun, im Werden und Vergehen; *atman* beweist die anthropologische Konstante einer weltimmanenten Seelensubstanz.

Die Kunst der Sonderpädagogik zeigt sich darin folgerichtig, die Menschen vor Ort in ihrer konkreten Existenz des Dorfes, des Slums oder des Stadtviertels anzusprechen, mit ihrer Dienstleistung und Seriosität zu erreichen, zu umwerben – somit auf ihre jeweilige autochthone Sichtweise und Bewertung von Behinderung zuzugehen und einen gemeinsamen Weg der Abhilfe, des Wissens, der ‚Selbsterlebensgestaltung‘ zu erarbeiten. Letztlich bedarf es einer Umorientierung und Aufgeschlossenheit der Sonderpädagogik selbst, reflexiv auf ihr Klientel hören zu wollen, von ihm lernen zu wollen, ihr eigenes Selbstverständnis auch hinterfragen zu wollen. Eine Chance dafür bietet zum

Beispiel die traditionelle Naturheilkunde, die vertrauensvoll noch von der breiten Bevölkerung angenommen ist und lebendig erhalten wird: eine moderne Erarbeitung und sonderpädagogische Applikation des altindisch-vedischen und seit 1929 fortlaufend erneuerten, erforschten *Ayurveda* bzw. dessen südindischen Pendant *Siddha* (vgl. Diesfeld 1995, 349) kann eine verbindlichere und transparente, überdies eine eigenkulturell ableitbare und begeisterte Gestalt von Behindertenhilfe kreieren. Ein erfolgreiches Exemplum einer Verknüpfung anerkannter Tradition und moderner Praxis ist die Anwendung von Yogaformen in der Geistigbehindertenpädagogik, der Aufbau einer Yogatherapie (*yogasana*) in Madras (vgl. Jeyachandran 1981; 1988), welche den psychophysischen Bedarf mit der edukativen Aufgabe kohärent vereinigt. Körperübungen (*asana*) und Bewegungssequenz (*vinyasa*), Atem- (*pranayama*) und phonetische Übungen (*mantra*) kristallisieren sich in einem gemeinsamen Ruhepunkt, restituieren die Einheit von Körperlichkeit, Wahrnehmung, Gemüt und Intellekt.

Gedenkt man der Aufgabe von Pädagogik in ihrer Schleiermacher'schen Trias aus *Behüten - Gegenwirken - Unterstützen* von menschlichen Entwicklungsläufen, in ihrem Ausbau menschlicher Denk- und Handlungsmöglichkeiten - dialektisch eingebettet in Prozessen zwischen personaler Emanzipation und sozialer Einbindung und Verantwortung -, gedenkt man erst recht der Sonderpädagogik in ihrer Intensivierung und Vertiefung dieser Prozesse an Betrachtung schwierigster und sogar brutaler Bedingungen des Aufwachens, so muss man der indischen Variation von Sonderpädagogik zugleich Leistung und Ungenügen konstatieren. Das Schicksal des felsenrollenden Sisyphos ist ihr ein naheliegendes, oftmals gefühltes, und muss ihr zugleich ein für die Zukunft aufgabenerfüllt unverdrossenes bleiben. Entscheidend sind die Menschen, die Personen, die sich ihr zuwenden und widmen. In der Schlussfolgerung erscheint vage die Utopie und Aufgabe einer landverbundenen Wissenschaft, wie sie Friedrich Albrecht zu formulieren begonnen hat. Utopie aber gehört zur Kategorie der Hoffnung (Ernst Bloch).

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Summary: The article that is presented here attempts to develop the description of Indian special education of E. Wilken/U. Wilken which was published in the "Handbuch Vergleichende Sonderpädagogik" (1987). The context, outside the bounds of European, shows the complexity of ones own speciality and the necessary dynamic of special education that depending on the location, reflects the different social cultural situations. This means responding to the local situation in respect to disability.

Résumé: Le présent article s'efforce d'appliquer à la pédagogie adaptée indienne les principes décrits dans le "Handbuch Vergleichende Sonderpädagogik" (Manuel de pédagogie adaptée comparée) (1987) par E. Wilken/U. Wilken. Le discours extraeuropéen fondamentalement montre la complexité de leur propre domaine et démontre la dynamique

nécessaire de la pédagogie adaptée, qui selon sa région d'application se trouve dans une socio-culture différente, c'est à dire répond à la situation de handicap locale.

Resumen: El artículo intenta de continuar escribiendo el fundamento descriptivo de E. Wilken/ U. Wilken sobre la Pedagogía Especial hindú, publicado en el "Handbuch Vergleichende Sonderpädagogik" en el año 1987. El campo de discurso no-europeo enseña fundamentalmente la complejidad de nuestra disciplina, así como también la dinámica que debe tener la Pedagogía Especial para contextualizarse en una cultura social y para responder así adecuadamente a la situación de la discapacidad en el medio local.

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New Approaches to the Total Development of Mentally Challenged Persons in India

Thomas Felix/David Zimmermann

In India, only a very small percentage of mentally challenged persons has access to formal education. Therefore, a holistic educational approach has to meet the child's needs while learning at school as well as at home. The 3 Cs Concept, in which the medium of shapes plays the key role, is such an approach. The *Central Institute on Mental Retardation* (CIMR) uses this educational concept in its schools as well as for the Home Based Rehabilitation programme. Because the family is involved in the whole learning process, acceptance and integration of the mentally challenged person are attained.

The topic of appropriate education for mentally challenged persons¹ is one of the long-time-discussed subjects of special education. It is almost impossible to find holistic approaches that aim to the development of all human functions. But even the basic right to education is not met for the majority of these people in India. The spreading of Home- and Community Based Rehabilitation can be an answer to the mentioned situation.

In the first paragraph of this article we want to discuss the current situation of mentally challenged persons in India. Then, the activities of a NGO that works with mentally challenged persons will be presented. Finally, we will come to the educational approach that was developed by this organisation.

Mentally challenged persons in India

Although there is no systematic survey about the number of mentally challenged persons, one can follow the assumption that 1% of the population belongs to that group. Other figures indicate a number of 2-3% of affected persons among the total population. Following these estimates, about 10-30 million people can be described as mentally challenged in a country like India, which has more than one billion inhabitants.

The *Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995* was passed to provide preventive and promotional aspects of rehabilitation like education, vocational training and employment. Concerning education, it emphasizes the right to free education including vocational training for people with disabilities in integrated and special schools till the age of 18. According to the act, it is the responsibility of the local governments to ensure the access to free education for every child from any part of the country. Additionally, the act called for the establishment of teachers' training institutions and the promotion of non-formal education for children with disabilities. The government

and Non Governmental Organisations (NGOs) agreed that most rehabilitation and education services should be implemented by the NGOs.

Actually, there are only about 650 special schools for mentally challenged persons in India with an average number of 50 students. There are no figures about the number of mentally challenged students in regular schools, but it is clear that only a very small percentage of these people have access to formal education.

Concerning the opportunities for the labour market for mentally challenged people, it must be stated that most of them have no access to formal employment. Three reasons can be listed:

1. there is no vocational training adequate for the needs of mentally challenged people,
2. the reservations in government employment (3%) are restricted to blind, hearing impaired and loco motor disabled persons,
3. there is no special labour market for people with disabilities as there is in most developed countries.

It is almost impossible to give clear information about the state of social integration, because there are such a lot of different local traditions and cultural patterns within India. Nevertheless, it can be said that mental disability is sometimes still seen as a stigma. Anyway, most families want to support their child; but the lack of knowledge of how to deal with their disabled wards, poor financial situations and the lack of transport convenience were seen as the main obstacles to sending their disabled children to school. Due to that fact, the integration of the family in the rehabilitation and educational process is essential.

Poverty, the lack of education and disability are related problems. Therefore, approaches have to be developed that help illiterate families to educate their child, too. There will be no participation of a person with disability in the society, if there is no acceptance of the child among the family.

To sum up, it can be stated that a holistic approach for mentally challenged persons has to contain the following elements:

- Appropriate developmental education that leads to the total development of the four human functions, i.e. motor, psycho-social, language (communication), cognition.
- Vocational training to give mentally challenged persons the opportunity for employment.
- Integration of the family in the educational process, including guidance on home education for those parents whose children cannot attend school. For the students attending school, the atmosphere at home and school should be congenial to identify and develop the creative potential of the child.

In the following, we want to present one example of a holistic educational approach that includes the above-mentioned requirements. A Non-Governmental Organisation, the *Central Institute on Mental Retardation* (CIMR), conducts this approach mainly in Kerala (Southern India) but also in other Indian states.

The Central Institute on Mental Retardation (CIMR)

Rev. Father Thomas Felix founded the CIMR in 1980. The members of the organisation are parents of the mentally challenged persons and their friends as well as well-wishers. It is the aim of the association to stimulate the total development of mentally challenged persons. Different operations are carried out under the roof of the CIMR:

Jeevan Prakash Child Centre

Established in 1991 as an Indo-German project, it aims at the early detection and prevention of developmental deficiencies of the newborns. This is the only centre in India for the special physiotherapeutic intervention *Vojta Therapy*. In the Child Centre, a professional team conducts Kinesiological Examination of newborn babies and children; identifies developmental deficiencies and demonstrates the appropriate physiotherapeutic intervention, which will assist normal growth and prevent further deterioration. At home, parents or siblings can give the therapy to the child through instructions given by the therapist.

Home Based and Community Based Rehabilitation

The family plays an important role in the growth and development of the person. In the case of a mentally challenged person, the responsibility of the family is to help him/her to attain self-reliance or independence through proper training.

After a mentally challenged individual is identified, the family members are given basic counselling and they are encouraged to involve actively in all ex-

ercises intended to normalise and rehabilitate the person affected. Such counselling is given by the CIMR staff, who visits the homes and educates the families on how to help with normalisation², development, growth and early rehabilitation of their disabled wards. The field-workers persuade local families to come together, on the basis of enhanced social awareness and to plan group activities.

Kits containing teaching aids, specially designed by the CIMR, and essential play-materials are distributed to groups of parents in order to use them for normalising the kids. The intention is that, although these persons cannot go to a special school, they should still be given all possible aids and catalytic services at their very homes, using their own parents and family-members as teachers and instructors.

Follow up was conducted to keep track of the development of these especially challenged persons and to observe whether the family members were continuing the training process as well as to assess the changes and positive results of the training.

This programme was also transformed to a *Community Based Rehabilitation Programme* bringing the children and parents together in a particular place in the community.

Schools

Two schools were started by the CIMR: Asha Kendram in Kochi in 1980 and the DCMR (*Developmental Centre for the Mentally Retarded*) in Trivandrum in 1984, without any government support or aid. The aim was to normalise mentally challenged persons and develop self-reliance in them. It was clear that normalisation could be achieved only if the child lived with his/her family and in the midst of his/her community and attended regularly school.

These schools are functioning under the *3 Cs Concept*, a shape-based curriculum that will be discussed later in this article. Along with the four main classes, i.e. *Knowing, Making, Selecting and Combining the Shapes*, the students of these schools receive training in physical exercises, sports and games and instrumental music, too. Vocational training is included in the curriculum from the very beginning. Classes take place in a kitchen, in bicycle and vehicle workshops. The students also work at an agricultural farm.

The schools admit children only after they have collected all information relating to the child and his/her family. The aim behind conducting such family programmes is to create necessary awareness among the family members about mental disability and to give them an idea about the worth of special children and to stress the importance of the involvement of par-

ents, family, society in the total development of a mentally challenged child.

Teachers' Training

The basic approach in regard to the education of the mentally challenged person is that it should be a harmonious process of partnership between his/her teachers and parents. A competent teacher of the mentally challenged is one who is able to thoroughly understand the person, his family, his environment and the social set-up in which he grows.

Verily rooted in the *3 Cs Concept*, the CIMR Teacher's Training Programme covers the below-mentioned four phases:

1. Global Understanding: Overview of mental disability,
2. Structured Understanding: Direct involvement in the work with mentally challenged persons,
3. Non-structured Understanding: Independent work in identification of and help to mentally challenged persons in the trainee's home areas,
4. Integrated, Total Understanding: Sharing of field experiences and deepening of gained knowledge at the CIMR.

The syllabus and guidelines followed by the CIMR for the two-year teacher-training course, leading to the award of diploma in Special Education are those that have been prescribed by the Rehabilitation Council, Government of India.

The 3 Cs Concept

But all these activities do not lead to the total development of mentally challenged persons if there is no adapted educational approach. While some people still stick to the old educational system, which does not meet the needs of mentally challenged persons, other ideas were implemented by western NGOs and some of them ignored the Indian conditions. That's why the CIMR implemented the *3 Cs Concept* that is used in its schools as well as for the *Home Based Rehabilitation*.

The *3 Cs* (comprehension – competency – creativity) is an educational approach, in which the medium of shapes plays a key role. It is based on the principle that everything in nature comprises shapes and colours. From these shapes, numbers, alphabets, measurements and associated words can be derived.

Well-structured and systematic interaction with basic shapes would enhance the basic functional abilities namely motor, psycho-social, language and cognitive. By handling concrete objects, they learn to know the shapes, make them, select them and combine them to form new complex shapes. The meaningful interaction

with circle, triangle, rectangle and square would enhance their ability to comprehend, build up competency and lead them to creativity.

In the schools, the *3 Cs Concept* is implemented in four classes, i.e.:

1. Knowing the Shapes (Concept Building): Here, the student achieves a definite understanding of the four different shapes, of colours, letters and numbers derived from these shapes and measurements through multisensory experiences.
2. Making the Shapes (Giving Shapes and Forms): Through the practical work with different materials and types of tools the student gains knowledge about the fabrication of different shapes.
3. Selecting the Shapes (Selection and Elimination): This class enables the student to select what is needed for a particular fabrication. During the work in a bicycle or vehicle workshop, he/she deepens the knowledge about the use of shapes, their measurements and colours.
4. Combining the Shapes (Combination and Measurements): This class gives the students an idea of combining different quantities of different materials to produce an entirely new product.

A shape-based curriculum can be used at home, too. Family members can make use of household articles like furniture, plates and other utensils to train the mentally challenged. Every object has shapes and colours; therefore, utensils of various forms and shapes exist in every household.

The CIMR has provided teaching materials, including a book (Felix 1998) and stencils in the shapes of circle, rectangle, triangle and square. These materials help parents and siblings to use their environment to educate their mentally challenged wards properly.

Conclusion

There is still a lot of work to be done. But by introducing low cost, easy-to-follow teaching aids and training methods relevant to rural and urban settings, improvements can be achieved. The teaching materials must be concrete to stimulate their senses. Within the scope of a National Project, a cooperation between the *Ministry of Social Justice and Empowerment* and the CIMR, more than 40 000 mentally challenged persons could be identified. The adapted teaching materials and the book "Home. A School" (Felix 1998) were first provided for the families with the aim to integrate mentally challenged persons into their families and then into community.

Therefore, the mentally challenged person will gain comprehension of his/her environment, compe-

tency in leading an independent life and creativity as a means of expressing their own personality.

Anmerkungen

1. Regarding the discussion of appropriate terms of this group, the authors prefer *mentally challenged persons* as it describes the human growth as a development with special challenges and not as a personally attributed and unchanging feature as the term *intellectually disabled* implies.
2. The idea of *normalization* was criticized for good reasons. Nevertheless, one should keep in mind that the *3 Cs Concept* was developed during the 1980s, when *normalization* was seen as the implementation of integration in many countries. The *3 Cs Concept* emphasizes the normalisation of living and learning conditions, not of the persons.

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Zusammenfassung: Nur ein kleiner Prozentsatz der Kinder mit geistiger Beeinträchtigung in Indien hat Zugang zu formaler Bildung. Ein ganzheitlicher Förderansatz muss deshalb sowohl Lernen in der Schule wie auch zu Hause ermöglichen. Ein solches Modell bietet das *3 Cs Concept*, in dem das Lernen über Grundformen ein zentrales Element ist. Das Konzept wird vom Central Institute on Mental Retardation (CIMR) sowohl in mehreren Schulen als auch für das Home Based Rehabilitation Programm angewandt. Da die Familie in den gesamten Lernprozess eingebunden ist, wird eine Akzeptanz und bessere soziale Integration des Menschen mit geistiger Beeinträchtigung erreicht.

Résumé: En Inde, seul un petit pourcentage de personnes handicapées mentales ont accès à l'éducation formelle. Un

concept éducatif global doit donc rendre possible l'apprentissage scolaire mais aussi à domicile. Le concept des "3 C" propose un tel modèle, dans lequel l'apprentissage par schémas joue un rôle central. Le Central Institute on Mental Retardation (CIMR) utilise ce concept éducatif dans ses écoles ainsi que dans les programmes de réadaptation à domicile. Comme la famille est impliquée dans tout le processus d'apprentissage, l'appropriation et l'intégration sociale des personnes handicapées mentales est renforcée.

Resumen: Solo un pequeño porcentaje de los niños con discapacidad mental en India tienen acceso a la educación formal. Por eso, un enfoque de rehabilitación holístico tiene que facilitar el aprendizaje en la escuela así como también en la casa. Un modelo adecuado ofrece el "Concepto 3 Cs" con su elemento central: el aprendizaje sobre formas básicas. Este concepto aplica el Central Institute on Mental Retardation (CIMR) en diferentes escuelas y en los programas de la rehabilitación familiar. Como las familias están integradas en el proceso educativo, se logra la aceptación y la mejor integración social de la Persona con Discapacidad Mental.

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Vocational Rehabilitation and Employment of People with Disabilities in Arab Countries: Interview with Yousef Qaryouti (ILO)

Andreas König (AK): Please describe briefly, as an ILO Specialist, the scope of activities you are undertaking with and for people with disabilities in the Arab Region.

Yousef Qaryouti (YQ): The scope of activities, which I am undertaking in the region, is guided by the mandate and policies of the ILO in the field of rehabilitation. As a specialized tripartite UN Organization established to assist the international community in overcoming the economic and social devastating outcomes of the 1st World War, the ILO, since its inception in 1919, has been striving for building peace through social justice and economic growth.

Setting up of international standards, preaching for decent work, full employment and equality of opportunities are central issues to the ILO work. Meanwhile, the ILO rehabilitation programme aims at promoting equal opportunities and integration of people with disability into the labour market. To this effect the ILO has adopted in 1981 *Convention No. 159 on Vocational Rehabilitation and Employment of People with Disabilities*.

Given its tripartite structure, the ILO promotes its mandate through its three social partners namely the Governments, and the Employers' and Workers' Organizations that it serves on equal basis.

Within the general framework of ILO's Strategic Objective (No. 2) on employment, my role as a *Senior Vocational Rehabilitation Specialist for the Arab Region* covers the following:

- Provision of technical advisory services to the ILO constituents and organizations of people with disabilities;
- review of national rehabilitation policies with the view to updating their provisions in conformity with international labour standards;
- building of national capacities through the provision of staff training;
- provision of support to organizations of people with disabilities for the purpose of enhancing their advocacy role;
- development and implementation of technical co-operation projects to strengthen national rehabilitation capacities and to set models of successful practices; and,
- dissemination of information and organization of national and regional seminars and workshops.

AK: ILO Convention 159 on Vocational Rehabilitation and Employment of Disabled Persons clearly requires consultation with organizations of and for people with disabilities in all matters regarding their training and employment. To what extent are people with disabilities in Arab countries organized to express their interest and vocal in lobbying for equal rights and full participation?

YQ: Generally speaking, the 'disability' movement in Arab countries gained substantive strength during the last decade. Whilst, organizations for people with disabilities have been around for a long time, these organizations started to emerge in the Arab countries only during the last fifteen years. At present such organizations exist in all Arab countries. Those in countries such as Lebanon, Palestine, Jordan are well established, while in other countries they still need serious efforts to strengthen their structures and influence.

In 2002 the *Pan Arab Federation for the Organizations of Disabled People* was established under the umbrella of the Arab League. This Federation was instrumental in the declaration of the *Arab Decade for People with Disabilities*.

ILO is working closely with organizations of people with disabilities to strengthen their capacities and to enhance their role in defending the right of disabled persons for equal rights and equal participation.

AK: The same ILO Convention 159 also asks for the involvement of workers' and employers' organizations in developing appropriate training and employment policies and practices for people with disabilities. How do the social partners in Arab States respond to this request?

YK: The involvement of Employers' and workers' organization in developing national policies and strategies in favour of disabled persons is very limited. ILO is encouraging both workers and employers representatives in the Arab region to assume a more effective role. This has led the ILO to organize several national and regional meetings over the past few years. We also make it a point to include Workers' and Employers' representatives in all our national and regional meetings and to involve those partners in all consultations conducted at the national level.

AK: Although women's educational achievements in Arab States have considerably improved in the last few years, in many countries, their educational indicators are still far behind those of their male counterparts. What is the access of girls and women with disabilities to education and training opportunities?

YQ: It is true that women's educational indicators in the region have improved substantially in most Arab countries. In fact, those indicators in countries like Lebanon, Syria, Palestine and the Gulf states are almost the same for those of their male counterparts.

However, this is not true when it comes to women with disabilities who are still marginalized. Whilst there are no reliable data on the extent of girls and women participation in special education and vocational training, trends indicate that their participation is far below that of the participation of either able-bodied women or disabled men.

ILO is paying special attention to this issue and works with all concerned parties and national authorities to enhance access of women with disabilities to special education and vocational rehabilitation services.

AK: Several Arab States have recently undertaken substantial steps towards political reform, including opening up of the media and strengthening of civic society. How can people with disabilities benefit from these developments?

YQ: The equalities of opportunities and the full participation of people with disabilities are human right issues in the first place. Steps towards political and legislative reforms and more recognition of human rights in the Arab countries will allow Arab societies to enjoy freedom, democracy, and protection of human rights.

Undoubtedly, people with disabilities will directly benefit from these developments. It is expected that international statements, Conventions and declaration concerning people with disabilities will be further acknowledged and implemented by the Arab authorities and societies.

Moreover under such open and more democratic environments organizations of people with disabilities will be in a better position to defend the rights of people with disabilities and to stand firm against violations of these rights. Finally, I have to say that this process is going to be gradual and needs the support of the international community.

AK: Where do you see your work priorities for the next five years?

YQ: The priorities differ from one country to another depending on the situation in each country. Nevertheless, the following are the common regional priorities:

- Development of appropriate strategies and programmes for mainstreaming vocational rehabilitation services into the regular vocational training systems and services;
- Assistance to a number of countries to develop national rehabilitation plans;
- Further support to strengthen the capacities of organizations of disabled persons;
- Advisory services to Workers' and Employers' organizations to get them involved more in the national policies for vocational rehabilitation and employment services for people with disabilities;
- Dissemination of information in Arabic concerning effective and successful practices in the field of vocational rehabilitation and employment; and,
- Assisting ILO constituents and organizations of disabled persons to establish national, regional and international networking relations for exchange of information and experience.

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Does co-payment for services decrease utilization of rehabilitation services for children with developmental disabilities?

Introduction

In 1995, the *National Health Insurance Law* was enacted in order to provide basic health insurance for all residents of the State of Israel with a defined health package, binding all public health service providers in Israel. By 1998, the *Law of Allocations* was passed and one of the significant changes enacted in that bill was the additional payment the insured was obliged to pay for medications and therapy included in the basic service package.

Several studies (Byrd et al. 1999, Reuveni et al. 2002) looked at the participation of patients in the added financing of care (co-payment) and found that paying for therapy or medications caused the patient to think in terms of cost effectiveness and may reduce the utilization of these services and low-income families tended to keep fewer appointments.

The Negev in the south of Israel represents the largest part of Israel (about 60% of the land), but with only half a million people (about 10% of the Israeli population). The Bedouin population in southern Israel (about 150,000 persons) has difficulty making use of medical and rehabilitation services due to limitations of language, cultural differences, economic difficulties and problems of accessibility (Borkan et al. 2000, Shvarts et al. 1997). With the enactment of the *National Health Insurance* legislation in 1995 the health budget was divided according to a capitation formula, meaning that the government pays the provider for its insured patients according to the number of the patients and the age. This law in fact made the large Arab families very 'attractive' to all health service providers, improved the primary medical care and the infant welfare therapy among the Arab population (Shvarts et al. 1997). In order to receive advanced medical services or ambulatory services, such as developmental assessment and rehabilitation therapy, the Bedouins must come to the *Soroka University Medical Center* in Beer-Sheva located far from where they live. The need for co-payment, the distance from the center and cultural differences have raised the possibility of higher non-compliance among the Bedouin population compared to the Jewish population. We therefore conducted a study to examine whether the health insurance legislation (those sections concerning co-payment) had influenced the compliance with therapy appointments of two populations, the Jews (the majority

group) and the Bedouins (the minority group), at the rehabilitation services provided by the *Zussman Child Development Center (ZCDC)* at the *Soroka University Medical Center* in Beer-Sheva (Lubetzky et al. 2004).

Experiences from our study

Our study included 6,249 summons of Jews and 2,255 summons of Bedouins from southern Israel scheduled for appointments at the center from January 1995 to December 1999. The therapy appointments were counted from the daily records of therapists in three rehabilitation fields (as the appointments for these three professions were similar): Occupational therapy, physiotherapy and speech therapy. A total of 8,504 appointments for rehabilitation therapy were counted for both populations of which two thirds were Jews and one third Bedouins. The rate of non-compliance with therapy appointments was significantly higher ($p < 0.001$) among the Bedouins than among the Jews, during the five study years.

Differences were found between non-compliance with therapy appointments during the years 1998-1999, when co-payment was required for rehabilitation therapy and the years 1995-1997, when co-payment was not required. Among the Jewish population, a significant difference was found between the two periods ($p < 0.001$). Among the Bedouins, the increase in the rate of non-compliance was more moderate and showed a significant trend ($p < 0.06$). We also used a logistic regression model to demonstrate the adjusted odds ratio and relative risk for each of the factors influencing noncompliance with rehabilitation therapy. The data showed that after excluding the potential influence of ethnicity and the type of rehabilitation service (physiotherapy, occupational therapy and speech therapy) co-payment led to a 16% increase in the risk for non-compliance with therapy appointments during the years 1998-1999, when co-payment was required, in comparison with the years 1995-1997, when co-payment was not required ($p < 0.005$). This model also showed that after excluding the potential impact of co-payment and the type of rehabilitation service, the patients' ethnicity lead to a 37% increase in risk for non-compliance with therapy appointments for Bedouins, in comparison with the rate of non-compliance with therapy among Jews ($p < 0.001$).

Discussion

As a result in the change of the law people in Israel since 1998 have been required to participate (co-payment) in the cost of medication and therapy provided by the basic service package, which has caused parents to think in terms of cost effectiveness, leading them to make less use of rehabilitation services, since it is not in the category of 'life-saving' measures (Galil et al. 2001). This process is especially likely to negatively influence the Bedouins living far from the rehabilitation center and considered to be culturally different from the Jewish population. Our study demonstrated that during the five year period (1995-1999) the Bedouin rates of compliance with therapy appointments were significantly lower ($p < 0.001$) than those of the Jewish population (Lubetzky et al. 2004). The reason being that people will use health services only, when the services are adjusted to their needs (Sparling 1991, Levine et al. 1992). These needs are influenced by the individual perception of the meaning of sickness and health, the value of the therapy offered and the effect of the therapy on the patient. Culture, lifestyle and availability of therapy are all factors that strongly influence these perceptions. Compliance with rehabilitation therapy among Bedouins was lower than that of the Jewish population (Galil et al. 2001), which we observed arise partially from the belief in destiny, as an important factor in the birth of a child and in his or her future life and partially from lack of confidence in the ability of the rehabilitation system to help their handicapped child. Therefore, culture has a major impact on the use of rehabilitation services and the perception of the parent concerning the importance of the rehabilitation therapy in raising a handicapped child.

We found that since 1998, there had been an increase in the rates of non-compliance with therapy among the Jewish population ($p < 0.01$), while the effect on the Bedouin population was much smaller, with only a borderline significance ($p < 0.06$). This was a surprising finding, because we would have expected that the compliance of the Bedouin population would have been lower than the Jewish population. We believe that the *cultural factor* seemed to have a greater impact on the Bedouin than the cost factor, since Bedouins used Western oriented rehabilitation services less than Jews, independently of the cost. It may be that those parents, who decided to make use of the rehabilitation services, in spite of the difficulties that arose from cultural differences, were not deterred by the cost. According to the National Health Insurance legislation, families entitled to Social Welfare Benefits are exempt from co-payment for health services. Many Bedouin families in the Negev

live on social welfare and therefore exempt from co-payment for rehabilitation therapy (Galil et al. 2001).

We also found (Lubetzky et al. 2004) that the ethnicity of the patients (in high correlation with culture and accessibility) had a greater impact on non-compliance with therapy appointments (OR=1.37) than the need to pay a fee for service (acceptance of responsibility forms; OR=1.16).

We conclude that the structure of the rehabilitation services provided to the peripheral population in Israel should be modified, where cultural aspects and customers arriving from different communities should be taken into account.

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H. Lubetzky/S. Shvarts/A. Galil/
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Impaired Citizenship and Forms of Exclusion (Ageing and Disability)

Reporting from the XIth National Conference of the Indian Association of Women's Studies in
Goa, India, 3rd-4th May 2005

The theme of disability and old age was introduced in the IAWS Conference for the first time at its XIth National Conference. The aim of this theme was to locate women's voices and experiences, especially those of the disabled and ageing who are excluded from citizenship and the feminist as well as the disabled agendas and movements.

History was made at IAWS with the introduction of this theme. This historical moment created an intersection of the women's movement with the disability movement in India. For the first time in an effort at mainstreaming by *Shanat memorial Rehab center*, an NGO from India, and *Abilis Foundation* of Finland, women with disabilities joined an IAWS Conference in large numbers.

The question that confronted the sub-theme was whether it fulfilled the designated aim of locating women's voices and experiences, especially those of the disabled and ageing who are excluded from citizenship and the feminist as well as the disabled agendas and movements. As far as their presence was concerned the aim was fulfilled. As to whether they contributed to that effort of discussing their exclusion? The high quality of paper presentation fulfilled this goal. What was left unfulfilled perhaps was the physical mainstreaming. The sub-theme drew both disabled and non disabled speakers but few non-disabled attended the subtheme, confirming the long road to be traveled.

The subtheme participants included most women leaders of the disability movement including the Disability Commissioner of India (a woman). There were both academics and activists. Though only 22 papers were received the quality of the majority of presentation and interaction was very high.

The sub-theme presentations were divided into four parts concepts, the movement and issues voiced by the disabled themselves and issues in general. It covered all types of disabled and disabilities. The theme attempted to underscore the concerns of disabled women in India. Rendered invisible by the structural and attitudinal amnesia, it was felt they have been denied both the traditional choices as well as participation in the labour force. While caste and class are considered significant by Indian feminists, impairment has not been considered as a difference that has analytical importance.

Another set of issues highlighted was of achievers and at least three papers concentrated on how women with disabilities despite their exclusion have become achievers at the global to grass root level.

As the conference is not only an academic gathering but brings together diverse initiatives of activists and scholars in this field to provide forums for interaction, networking, research, documentation and dissemination of information on women's issues. The ultimate aim of IAWS has been to bring about social a change and promote the cause for equality for women. In keeping with this aim the sub-theme used it to analyze the academic status and activist needs. As a participant said: "I, personally as a Woman with Disability, and as a member of Disabled women's community, urge upon the leaders/stakeholders of women's movement to recognize the atrocious injustice done for decades with women and girls with disabilities world over and take effective measures to bring solidarity among all women without any further delay."

Four sessions, focusing on citizenship, challenges in disability, inclusion of disability aspects into feminist theory, and policy covered a wide range of paper presentations, including:

- Citizenship and the links between the different models of disability.
- Disability Act...bringing about exclusion or inclusion?
- Abuse and Activity Limitation: Domestic Violence Against Disabled Women in Orissa & India.
- Disabled Women: An Excluded Area Of Indian Feminism.

The special census conducted in India was analyzed from a feminist perspective:

- Beyond Enumeration - Reflections on the National Data on Disability in India.
- Cinema and the Female Disabled Body: Reinforcing Masculinity.
- Women, Disability and Disasters. Married Disabled Women in India.

The papers highlighted the following:

- Hierarchy where women's movement is controlled by non-disabled women and disabled women lack the confidence and ability to raise their voice.
- That disabled women have been missing both from the feminist theory and practice as well as the male centric disability movement and a major reason has

been that the feminist discourse attempted to connect disability and feminism by arguing that disabled women must deal with the twofold but separate oppressions of being a woman in a sexist society and being disabled in an ableist society. An implicit assumption of the additive framework is that gender, disability, impairment, and sex are binaries.

- Some specific issues discussed included women and mental illness and women during disasters.
- Vulnerability to sexual abuse both within and outside the home is also increased in the case of women with disabilities.
- While some parents may invest much time and resources in the care of their disabled daughter, the position of the latter may grow more marginal even within her own household as she grows older and is not able to chart a passage along the normal pathways of matrimony and maternity.
- Cinema and the Female Disabled Body were Reinforcing Masculinity.
- Invisibility of disability within feminism occurs because of mechanisms similar to those that have made women in general invisible in the larger society.
- The feminist discourse as well as the disability theory must take account of significance of including disabled women's experiences into theoretical discourse.
- A preliminary examination of the recording of data on disability over the last few decades and the problems thereof was explored on how the results and categories revealed by both the Census as well as the NSS reflect an evolution in understanding the nature of disability brought about through a process of struggle to be included and recognized as people of this country.

The closing session of the Conference was not only

devoted to the reporting of various presentations but also the resolutions passed by the Sub-themes. In this context the resolutions passed were as below:

As disability cuts across all categories of class and caste, we the participants of sub-theme eight resolve:

1. We appreciate the contribution made by the Indian Association of women's Studies in creating a historic event by including its disabled members.
2. Disability should be a part of the general theme of Women's Studies and movements in India in the future and in the IAWS conferences.
3. We acknowledge that the disabled citizens are deprived of their basic social political, economic and cultural rights, we appeal to IAWS and other agencies to make endeavors to include disability perspective in women's studies programs and its movement.
4. Fulfill the *Millennium Goals* and goals set by the *Beijing Platform for Action* and CEDAW in the context of women with disabilities.
5. Recognizing that there has been a shift from the medical to social understanding of disability, we the participants appeal to the IAWS to arrange for a main plenary so that the issues are discussed before all participants and is not confined to disabled participants and the converted do not carry out a discourse with the converted only.
6. Recognizing the mobility and communication issues that disabled women face in participations of such meetings we appeal that future conferences are fully accessible and disable friendly.
7. We also appeal that volunteers be assigned to those who need them since we believe in a truly inter-dependent society.
8. Let us make a beginning.

Asha Hans

Education for all: A Report from the International Symposium "Inclusion and the Removal of Barriers to Learning, Participation and Development"

„Inclusion and the Removal of Barriers to Learning, Participation and Development“ was the topic of the International Symposium in Bukittinggi/West Sumatra, Indonesia from September 26-29. Some of the presentations took place in the Resource Center in the nearby community of Payakumbuh, the first community in Indonesia to embrace *Inclusive Education* (IE). Students who have visual impairments are integrated in regular schools.

Over 500 participants from 30 countries formed a diverse conference group: people from ministries, NGOs, INGOs, UNICEF, UNESCO as well as university students, lecturers and a few teachers. Contrary to the German understanding of integration, the term IE means *Education for all* (EFA) and refers not only to people with disabilities, but also to children from poor families, ethnic minorities, street children, children with HIV/AIDS etc., in short: children who are often

not reached by formal education. In most of the presentations and discussions IE was linked to the concept of *Child-Friendly Schools* (CFS) and related to a *Child-Rights-Based-Approach*, both supported and developed by UNESCO and UNICEF. Child-friendly schools are defined as *child-seeking schools*, i.e. actively identifying excluded children, *child-centred schools* as well as an *environment of good quality*, promoting good quality teaching and learning.

To improve the quality of schools and teaching, teachers were acknowledged as the key-persons for change: What makes a difference in teaching are the teachers in the classrooms and head teachers who back them up. To achieve this, teacher training and support was seen as a crucial lever. Most presentations discussed teacher training from an administrative and organisational perspective and introduced different TOT (*Training of Trainers*)- and TOTT (*Training of Trainers for Trainers*)-programmes.

As teachers and advisors ourselves, the following

questions remain unanswered:

- Which steps have to be taken to prevent the watering-down effect of TOTT-/TOT-programmes?
- How can the statement "Difference enhances everybody's learning" be made practicable for everyday teaching?
- Which practical support and which special knowledge do teachers need to provide all children with adequate individual learning opportunities?
- Which consequences for the school system and the curriculum have to be considered when students with learning disabilities learn in inclusive classes?

More information about the discussed topics as well as the recommendations written by the organising committee and some of the speakers can be found on the new website of the *Enabling Education Network Asia* (EENET): www.eenet.org.uk.

Vivien Heller & Kirstin Lee Bostelmann

CAHD: Making the society responsible for the inclusion of people with disabilities in mainstream development

Community Approaches to Handicap in Development (CAHD) is a (another) strategy for mainstreaming disability in development. With the CAHD matrix a concrete framework for action towards inclusion of people with disabilities is proposed. CAHD has been developed in 1996 in Bangladesh and is today implemented by seven projects in four Asian countries, Bangladesh, India, Nepal and Philippines. Through the implementation of the CAHD approach, the different projects provide innovative examples of effective inclusive practices. Experiences over the last three years show how CAHD initiates a paradigm shift in the organisations from a client focussed to a community centred approach for development. Sustainable structures and procedures for implementation are created through alliance-building with the local government and community organisations.

Introduction

Community Approaches to Handicap in Development (CAHD) is a rights-based strategy for the inclusion of people with disabilities in mainstream development activities. CAHD is a strategy aimed at social

change. Activities under CAHD are designed to change the attitudes of people and organisations towards persons with disabilities. The community is targeted as a whole in order to recognise equal rights and opportunities for people with disabilities, as well as access to and inclusion in mainstream development. CAHD emphasises further more on accelerating inclusion, recognising disability as a cross-cutting general development issue, involving people with disabilities actively, and addressing poverty through income generating projects.

Historical perspective

CAHD was developed in 1996 by the *Centre for Disability in Development* in Bangladesh in close partnership with *Handicap International* (HI) and *Christoffel Blindenmission* (CBM). In 1997, CAHD was initiated in India and Nepal, with additional support from the European Commission. The approach was introduced in the Philippines in 2001.

The translation of the CAHD concept in the Philippines has shown interesting results in how the approach can be adapted to other socio-economic con-

texts outside South-Asia.

Three HI and CBM partner organisations demonstrate that CAHD not only provides the means to general development agencies on how to include the disability issue into their programme, CAHD also initiates a change in the perspective of implementation in specialised and mainstream development organisations. This paradigm shift is from being client focused to a community centred development perspective. It generally widens the focus of implementation and makes an organisation look at general development issues, such as participatory approaches, community organisation and poverty alleviation through income generating activities. Those issues are often the priority for the target population, and the disability issue though becomes the entry point for community development.

Components

Through CAHD a concrete framework for actions towards mainstreaming people with disabilities is proposed. Activities are recommended under four components, namely:

- Social Communication
- Inclusion & Rights
- Rehabilitation and
- Management

Social Communication

Providing knowledge and information to the general population, particularly community groups, such as women's, micro-credit, self-help and youth groups, on what disability is, how to prevent and identify disability very early and where to go for help. For example, flash-cards, booklets, brochures and posters are utilised for illustration in all countries. Special events, such as puppet shows and street dramas, are especially well developed in India and Nepal.

Inclusion & Rights

This is one of the most important tenets of CAHD and implementing bodies are encouraged to focus on activities under this component. Examples of promoting the rights and the inclusion of people with disabilities can be: lobbying with school directors and teachers for the inclusion of children with disabilities in schools; mediation with local employers and vocational trainers; organising campaigns for human rights for all; support Disabled People's Organisations in their advocacy activities. Examples of outcomes in pilot projects: Child Clubs in Nepal include children with disabilities in activities and the campaign for

children's rights; persons with physical, sensorial and mental disability have access to work and income; a local government in the Philippines has signed responsibility for activities with people with disabilities; the disability issue is included in the government Poverty Reduction Strategy Paper in Bangladesh.

Rehabilitation

Under *Rehabilitation*, trained fieldworkers from development organisations identify and support persons with disabilities and family members through referring them to specialised services, mobility training, activities of daily living and basic education. More than 7,000 persons have received primary rehabilitation therapy (PRT) through the project in Bangladesh. The project in Nepal has extended PRT services to over 3,000 people. This is possible through referral systems that are built in all project locations as well as through the production and distribution of assistive devices (e.g. wheelchairs, spectacles, hearing aids).

Management

This component refers to the strategic planning of activities, building a system of organisations, experience sharing, documentation and organising access to information. In this sense, activities of 225 organisations in Bangladesh are for example coordinated by the Initiating organisation, the *Centre for Disability in Development* (CDD). Further more, information sharing and impact monitoring systems are developed, and staff from non-government, government and people's organisations are oriented and trained.

Activities are best carried out through a network of local, regional, national and international partner organisations.

CAHD is most effectively implemented on three levels of intervention in the society. The local (primary) level includes people with disabilities, their families and neighbouring community. The district or national (secondary) level comprises formal community based groups, people's organisations, local and regional NGOs and development actors. The national or international (tertiary) level refers to national and international organisations, government and non-government development actors, disabled people's organisations and federations and training centres.

Projects in the Philippines and their experience with CAHD

Simon of Cyrene Children's Rehabilitation and Development Foundation, Inc. (SCCRDFI) in the province of Albay, Philippines initiates and coordinates ac-

tivities under CAHD in three rural barangays (villages). The innovative strategy here is that the local government (LGU) has been made fully responsible for all activities with people with disabilities. The Mayor has signed the LGU's full commitment in an agreement. A CAHD technical team is composed of representatives from all relevant line agencies, who initiate changes in their respective programmes and policies. The Municipal Social Welfare Officer has been designated *CAHD Coordinator*. She cooperates with the newly formed People's Organisations in the three barangays. A physiotherapist has been hired by the municipality and operates in a rehabilitation centre, opened in the premises of the LGU. Further more, initiatives are undertaken by the LGU to include all school aged children in regular schools or to provide individual school education in cases where inclusion is difficult. Simon of Cyrene acts as supporting, facilitating and coordinating organisation.

The *Philippines Service of Mercy Foundation, Inc.* (PSMFI) coordinates CAHD implementation in Cagayan de Oro/Mindanao, since 2001. The activities focus on the organisation and strengthening of the community in one barangay and the creation of a region-wide network for resource mobilisation. The innovative approach here is that the CAHD matrix – the framework for action – is used as a concrete tool for social mapping. Through the matrix, areas of activities are identified where services through existing organisations are lacking. In PSMFI's target area, as an example, the lack of services was identified in the inclusion of children with disabilities in schools at secondary and tertiary level. PSMFI successfully responded to the problem in initiating developmental centres for children with special needs in regular schools, where children are prepared for inclusion in regular classes. Several children with special needs are in addition already included in mainstream classes. Further more the introduction of the advanced studies in special education for school teachers in three universities in Cagayan de Oro, has prepared 400 teachers for the inclusion of children with special needs.

Kasamaka CBR Foundation Inc. in Makati City, Metro Manila, applies CAHD in four urban barangays through alliance-building with *Community Organisations* (COs) which are made fully responsible for the inclusion of people with disabilities. Kasamaka's cooperation with a particular community starts through contracts that are signed with individual focal persons. They act as models in their barangay. Their role is to identify people with disabilities, coordinate their assessment, refer them, and start organising a core-

What does CAHD mean?

COMMUNITY: People, their families and the organisations that influence their daily lives.

APPROACHES TO: The two-way, inter-active relationship within communities needed to change attitudes so that disabled persons will be included and have access to the services and assistance that will minimise their disability and maximise their personal development.

HANDICAP: Social exclusion: not recognising the existence of disabled persons, excluding them from society, and not providing services to meet their needs.

IN DEVELOPMENT: Including disabled persons in the continuing processes: of increasing personal freedom; and, of sharing in more equitable distribution of the world's resources.

group in view of the creation of a CO. Kasamaka supports COs during a period of 3-4 years, before withdrawing from a community and extending its services to other needy areas. In a very innovative and exemplary way, Kasamaka has defined the detailed phasing out process, as well as indicators which define the right moment for phasing-out of a community/barangay. In different phases, the CO is oriented and trained in its institutional capacity. Its legal registration is ensured. The phase-out indicators are set in the fields of governance, project implementation, advocacy, network and funding base. The CAHD approach helps to adapt these indicators to a mainstream development perspective.

Conclusion

The experience with CAHD over the last three years shows that inclusive practices towards mainstreaming people with disabilities in development services are innovative and effective. The fact that CAHD implementation in four countries differs according to the specific contexts of the project sites as well as the experiences of the initiating organisations underlines that CAHD is a flexible strategy. It enhances social investment through the community, and the creation of sustainable implementation structures and procedures, especially in the strategic cooperation with the local government and community organisations. Projects implementing the CAHD approach, contribute to reducing poverty and implementing equal human rights and opportunities for all.

Ingar Düring

Asian and Pacific Decade of Disabled Persons and Biwako Millennium Framework—A Survey

Almost three years have passed since the inception of the second *Asian and Pacific Decade of Disabled Persons* in 2003. *United Nations Economic and Social Commission for the Asia and Pacific* (UNESCAP) has been the regional focal point to promote implementation of the *Biwako Millennium Framework for Action towards an Inclusive, Barrier-free and Rights-based Society* (BMF), the regional policy guideline for the Decade. UNESCAP has convened regional workshops, published good practices, and conducted a survey, particularly focusing on the policy formation aspect of the BMF targets, for this purpose.

Reporting at the past workshops and the responses from the survey (23 Governments in 2004 and 3 in 2005) reveal that the concept of and guidelines in the BMF have been increasingly integrated into national policy frameworks and initiatives. So far, at least 20 Governments have national coordination mechanism on disability matters and at least 15 Governments have either completed development of national plan of action on disability or started the process, in line with the BMF. Republic of Korea and the Philippines have instituted their own Decade of disabled persons along with the regional Decade and the action plan. Countries in the Pacific, such as Cook Islands, Solomon Islands, and Vanuatu made remarkable progress in policy and action plan development. Australia, New Zealand, and Hong Kong/China, respectively, already have a comprehensive anti-discrimination law on disability and their enforcement mechanism and practices have inspired other countries in the region. In 2005, Indian Human Rights Commission has published compilation of cases on disability rights. These are a few examples of the recent achievements.

Due to lack of common definitions and classification of disability, and national capacity, wide discrepancies in disability prevalence rate (which ranges from 0.96 to 19.91 per cent) remain as a big challenge for effective policy development and implementation. However, significant efforts have been made during the last three years. UNESCAP Statistics Division has been building capacity-building of statisticians in

countries of the region, particularly, applying WHO-ICF concepts in disability data collection, and is currently managing pilot projects targeted at 7 countries, which would, in the end, help integrate disability component in the next census or survey in the targeted countries and others.

Culture and mechanism to ensure persons with disabilities in decision-making processes have been increasingly established. According to the BMF survey, 19 countries have mechanism to include persons with disabilities in formulation or monitoring of laws. In Afghanistan, Deputy Minister of Ministry of Martyr and Disabled is a person with disability. In the Philippines, a person with disability is a member of national anti-poverty commission.

The BMF has 7 priority areas with 21 targets, and 4 major strategic areas with 17 strategies. UNESCAP activities has shed lights on many of these, including linkage between poverty and disability, community-based rehabilitation, promotion of disabled persons employment in multinational corporations, women with disabilities, self-help organizations of persons with disabilities, and a proposed international convention on promotion and protection of dignity and rights of persons with disabilities. Also, inter-regional dialogue was promoted in collaboration with the *Asia-Pacific Development Center on Disability* (APCD), a technical cooperation project of the Government of Thailand and the Government of Japan through *Japan International Cooperation Agency* (JICA).

In 2007, the mid-point of the Decade, UNESCAP will organize a high-level intergovernmental meeting, in which, the BMF implementation will be assessed and the strategies for the second half of the Decade will be formulated. Towards this, UNESCAP continues to make efforts to promote all aspects of the BMF targets and strategies. And, in view of the accelerating development towards the proposed convention, UNESCAP will continue to function as the issue catalyst and policy advocate.

Aiko Akiyama

Rechte behinderter Menschen durchsetzen

Ein Bericht vom Workshop „PRSP & Behinderung“ in Daressalam/Tansania

Rund 90 Vertreter von Behindertenselbsthilfegruppen, tansanischen Ministerien, UN-Organisationen und internationalen Hilfswerken wie der *Christoffel-Blindenmission* (CBM) kamen vom 27. bis 29.9.2005 in Daressalam/Tansania zusammen, um gemeinsam zu beraten, wie die Maßnahmen, die im landesweiten Armutsbekämpfungsprogramm (*Poverty Reduction Strategy Paper*, PRSP) vorgeschlagen werden, in die Tat umgesetzt werden können.

Dieser Workshop ist Teil eines Vorhabens, das von der Weltbank finanziert und gemeinsam von der Christoffel-Blindenmission und Handicap International durchgeführt wird. Handicap International erstellt ein Handbuch, das zur Berücksichtigung von Menschen mit Behinderung in den Strategien zur Armutsbekämpfung (PRSP) einen wesentlichen Beitrag leisten soll. Das Handbuch wurde auf dem Workshop in Tansania erprobt und soll soweit weiter entwickelt werden, dass es auch in anderen Ländern einsetzbar ist.

Am ersten Tag des Workshops wurde das tansanische PRSP und die Arbeit der Selbsthilfegruppen vorgestellt und die Situation und die Bedürfnisse von Menschen mit Behinderungen diskutiert. Am zweiten Tag wandten sich die Teilnehmerinnen und Teilnehmer dann den konkreten Fragen des Armutsbekämpfungsprogramms zu. In Arbeitsgruppen ging es darum, die entscheidenden kritischen Punkte zum Thema Behinderung herauszuarbeiten:

- eine hohe Sterblichkeitsrate von behinderten Kindern
- Ausschluss vom Schulunterricht
- die weit reichende Stigmatisierung und Ausgrenzung in der Gesellschaft
- öffentliche Gebäude, die nicht zugänglich sind für Rollstuhlfahrer
- Informationen, die für blinde Menschen nicht erreichbar sind
- Antidiskriminierungsgesetze, die nicht umgesetzt werden

Eine lange Liste. Was kann dann Einbeziehung von Menschen mit Behinderungen in allen Lebensbereichen bedeuten? Die Diskussionen darüber waren emotional, ausgesprochen engagiert und konstruktiv. An ihrem Ende wurden Lösungsansätze formuliert:

- Forderungen an die Regierung, Zugang zu öffentlichen Gebäuden zu erlangen
- Einhaltung von Gesetzen zur Anstellung von Menschen mit Behinderungen
- Aufklärungsmaßnahmen in der Gesellschaft über Behinderung

- Schulung und Sensibilisierung von Lehrern und Krankenschwestern

Diese Vorschläge wurden am dritten und abschließenden Tag des Workshops zu konkreten Strategien mit klaren Zielen und festgelegter Aufgabenverteilung innerhalb des tansanischen PRSP weiterentwickelt. Am Ende des Workshops stand dann der grobe Aktionsplan für ein Bündnis „Behinderung und Armutsbekämpfungsprogramm“. Es war ein ganzes Stück Arbeit, Maßnahmen zu entwickeln, die sich auf Vorgaben aus dem Armutsbekämpfungsprogramm bezogen, und zugleich die Einzelschritte so konkret zu beschreiben, dass sie auch in die Tat umgesetzt werden können.

Ein Beispiel: Im Armutsbekämpfungsprogramm wird im Ziel 2 „eine Verbesserung der Überlebenschancen, Gesundheit und Wohlergehen aller Kinder und Frauen und insbesondere der verwundbaren Gruppen wie Menschen mit Behinderungen“ angestrebt. Die Arbeitsgruppe, die sich mit diesem Thema auseinandersetzte, schlug als erste konkrete Maßnahme Trainingskurse zum Thema Behinderung für Mitarbeiter der verschiedenen Ministerien vor, vor allem aber des Gesundheitsministeriums, um somit einen ersten Schritt zu tun, um Vorurteile Menschen mit Behinderungen gegenüber abzubauen. Ähnliche Maßnahmen wurden in den anderen sechs Arbeitsgruppen zu den Themen Bildung, freier Zugang, Regierung und Verantwortlichkeit, HIV/Aids, Beschäftigung und berufliche Ausbildung sowie soziale Sicherung entwickelt, die nun zu einem übergreifenden Aktionsplan zusammengefügt werden. Im nächsten Schritt verpflichtete sich jede teilnehmende Organisation, mit einem festgelegten Beitrag zum Gelingen des Vorhabens beizutragen.

Um den gesamten Aktionsplan umzusetzen, wurde ein Implementierungskomitee von 13 Personen eingesetzt, das sich aus dem bisherigen Planungskomitee zusammensetzt sowie aus Vertretern von UN-Organisationen, tansanischen Ministerien, der Zivilgesellschaft und internationalen Hilfswerken. Der Aktionsplan soll sich über einen Zeitraum von fünf Jahren erstrecken und das zweite PRSP begleiten. Im tansanischen Haushalt sind 51 % für die Umsetzung des PRSP eingestellt. Dreh- und Angelpunkt für Menschen mit Behinderung wird sein, wie die sie betreffenden Aktionspunkte des PRSP sich im Haushaltsplan wiederfinden werden.

Andreas Pruiskien

NEWS

The Disaster Management Bill 2005 leaves 70 million disabled people endangered

In what has now become a routine, so far as the national policies are concerned, the Government of India has forgotten about its approximately 70 million disabled citizens while framing *The Disaster Management Bill 2005*. This unfortunate omission of disability related concerns have greatly irked the disability sector.

As if in a providential act of a sad warning, the recent South Asian earthquake has once again revealed vulnerability of the old, young and disabled people during times of disaster. But these warnings seem to be going in vain, as the Government and its agencies fail to address the issue of focus on disability in its disaster management mechanisms and now the Bill itself.

It is surprising for the disability sector that in the aftermath of the Asian Tsunami disaster the impact on people with disabilities, both the immediate and long-term, was emphatically and empirically highlighted, using research studies, yet the Government has failed to take cognisance of these inputs and demands.

National Centre for Promotion of Employment for Disabled People (N.C.P.E.D.P.) in association with *Disabled People's International - India* and *Vidya Sagar* had launched a campaign to get disability issues included in the relief and rehabilitation work for the victims of Tsunami. As part of their efforts to gather facts and information, they visited Andaman & Nicobar Islands, which has suffered the heaviest loss in India.

An All Party meeting was convened on 9th January 2005 to discuss the relief, rehabilitation and reconstruction efforts in the Tsunami affected areas and assistance provided to the neighbouring countries in the region affected by the Tsunami. It is in this meeting that the Government informed that a Bill would be introduced in the Parliament during the coming Budget Session for establishing the *National Disaster Management Authority* and the *Central Legislation on Disaster Management* in the country.

Disasters affect over 56 million people and kill over 5000 people in India, annually. The annual economic loss on account of disasters is estimated at 1,884 million dollars.

According to Oxfam, to better the survival chances of people with disabilities during disasters, and to address their long-term needs call for:

- An informed debate that is the responsibility of every constituent of the civil society, especially the media, academicians, activists and other interest groups.
- A "reality check" by humanitarian agencies to ensure that disability is an integral part of their disaster response programme.
- Paradigm shift in disability and disaster related policy making, to endorse the needs and rights of differently abled people.

It is important that the world recognises disaster-affected people not as just passive victims, but as active survivors. Recognising that humanitarian assistance is not an act of charity but a survival right of the affected, may be the first step to break the poverty-vulnerability-disaster-disability cycle.

Quelle: <http://www.dnis.org/>

Fairer Handel und Behinderung

In einem Kooperationsprojekt von *Behinderung und Entwicklungszusammenarbeit* (bezev) und der *Arbeitsgruppe Menschen in der Entwicklungszusammenarbeit* (miezag) der Universität Dortmund ist eine erste Bestandsaufnahme der Beteiligung von Menschen mit Behinderung am Fairen Handel durchgeführt worden. Wichtiges Ergebnis der Recherche ist, dass der Faire Handel eine gute Möglichkeit zur Einkommenssicherung und gesellschaftlichen Teilhabe von Menschen mit Behinderung darstellt. Zusammengefasst sind die Informationen und Ergebnisse zum Fairen Handel in einer Broschüre, die auch eine erste tabellarische Übersicht über die Beteiligung von Menschen mit Behinderung beinhaltet.

Die Broschüre ist als pdf-Dokument abrufbar unter: www.bezev.de oder www.miezag.de oder erhältlich bei: Behinderung und Entwicklungszusammenarbeit (bezev), Wintgenstr. 63, 45239 Essen, Email: info@bezev.de oder AG Menschen in der Entwicklungszusammenarbeit (miezag), c/o AstA der Universität Dortmund, Emil-Figge-Str. 50, 44221 Dortmund, Email: info@miezag.de.

Millenniumsziele kaum noch erreichbar

Die Millenniumsziele können insbesondere im südlichen Afrika nur noch erreicht werden, wenn in den Industrieländern eine Abkehr von der Politik des *business as usual* erfolgt. Zu diesem Ergebnis kommt der Vierte Bericht der *Gemeinsamen Konferenz Kirche und Entwicklung* (GKKE) zur Halbierung der extremen Armut. Zu den dringend notwendigen Maßnahmen zählt demnach auf Seiten der Geber eine Erhöhung der Leistungen der Entwicklungszusammenarbeit. Ein Zeitplan für die Erreichung des 0,7-Prozent-Ziels müsse auch von der Bundesregierung verbindlich verabschiedet werden. Auch die qualitativen Elemente der Entwicklungszusammenarbeit müssten verbessert werden: Geberharmonisierung und Programmfinanzierung blieben auf der Tagesordnung.

Bezug: GKKE, Evangelische Geschäftsstelle, Charlottenstraße 53/54, 10177 Berlin, Tel.: 030 20355-307, Fax: 030 20355-250, E-Mail: J.Hambrink@gkke.org, Internet: www.gkke.org

Ausstellung zum Thema Landminen

Die Greenpeace-Gruppe in Ansbach hat in Kooperation mit SODI und der Friedensinitiative Berlin-Zehlendorf die Exponate eines Plakatwettbewerbs der Studenten der Kunsthochschule Berlin-Weißensee und der Fachhochschule Potsdam zum Thema Landminen in der Zeit vom 14. Juli bis zum 7. August im Rahmen der „Grünen Nächte“ der Stadt Ansbach sowie in der Hochschule in Neuendettelsau einem interessierten Publikum zugänglich gemacht. Interessenten, die die Ausstellung (40 Plakate im Rahmen bzw. in Folie ver-

schweißt 70 x 100 cm) im Jahr 2006 in ihren Einrichtungen oder Orten zeigen möchten, wenden sich bitte an die SODI-Geschäftsstelle, Gravesmühlener Str. 16, 13059 Berlin, Tel.: 030 928 6047, Fax: 030 928 6003, E-Mail: info@sodi.de

Quelle: SODI-Report, 3-2005

Sexualität von Menschen mit Behinderung in Indien immer noch Tabu

Ein Großteil der jungen Menschen mit Behinderung in Indien hat keinen Zugang zu Programmen zur Förderung der sexuellen und reproduktiven Gesundheit, weil diese ihre speziellen Belange nicht berücksichtigen: So lautet das Fazit einer Studie der MacArthur Foundation in Delhi. Zurückzuführen sei dies auf weit verbreitete Vorurteile. So würden Menschen mit Behinderungen oft als asexuell angesehen oder es werde befürchtet, dass sie ihre Beeinträchtigung an ihre Kinder weitergeben könnten. Die Folge sei, dass Sexualität für diese Bevölkerungsgruppe ein Thema sei, das Unbehagen und Selbstzweifel hervorrufe. Obwohl es keinen Grund gebe zu glauben, dass Frauen mit Behinderungen keine sexuelle und reproduktive Gesundheitsfürsorge benötigten, berücksichtigten Gesundheitseinrichtungen ihre Bedürfnisse nicht: So seien Mitarbeiter nicht speziell geschult und die nötige Infrastruktur wie weite Flure für Rollstühle oder hohe Untersuchungstische nicht vorhanden, so Dr. Renu Addlakha, der die Studie leitete.

Quelle: www.dnis.org

VERANSTALTUNGEN

- 09.12. - 11.12.2005 Seminar für RückkehrerInnen: Entwicklungszusammenarbeit als soziale Aufgabe und praktische Erfahrung - Teil III
in Kooperation mit der Akademie Frankenwarte in Würzburg
Information: Behinderung und Entwicklungszusammenarbeit e.V. (bezev), Wintgenstr. 63, 45239 Essen, Tel.: 0201/40 87 745, Fax: 0201/40 87 748, E-Mail: info@bezev.de, www.bezev.de
- 06.01. - 07.01.2006 EU-India Conference: Circles of Support (CoS) in India and the EU - towards person-centred community inclusion networks in Bhubaneswar, Indien
Information: Prof. Dr. Evamarie Knust-Potter, Fachhochschule Dortmund, Emil-Figge-Str. 44, 44227 Dortmund, Tel.: +49 231 755 5192, Sekr.: +49 231 755 6832, Fax: +49 231 755 6833, E-Mail: knust-potter@fh-dortmund.de, Internet: www.cos-transnational.net
- 01.02. - 04.02.2006 International Conference on Aging, Disability and Independence (ICADI), St. Petersburg, FL, USA
Information: ICADI, University of Florida, Box 100164, Gainesville, FL 32610, USA, Tel: 001-352-273-6126, Fax: 001-352-273-6042, Email: icadi@p.php.ufl.edu, www.icadi.p.php.ufl.edu
- 03.03. - 05.03.2006 Entwicklungszusammenarbeit als soziale Aufgabe und praktische Erfahrung - Teil I. Einführungsseminar zur Vorbereitung von Arbeits-, Praktikums- und Studienaufenthalten in Afrika, Asien und Lateinamerika
in Kooperation mit der Akademie Frankenwarte in Würzburg
Information: Behinderung und Entwicklungszusammenarbeit e.V.
- 19.05. - 21.05.2006 Symposium „Behinderung und ökologische Nachhaltigkeit in der Einen Welt“ (Arbeitstitel). Eine offizielle Veranstaltung im Rahmen der UN-Weltdekade Bildung für nachhaltige Entwicklung, Gustav-Stresemann-Institut, Bonn
Information: Mirella Schwinge, Universität Wien, Institut für Bildungswissenschaft, Arbeitsstelle für international und interkulturell vergleichende Heilpädagogik, Universitätsstr. 7, A-1010 Wien, Tel.: 0043-(0)-1-4277-46804, Email: Mirella.Schwinge@univie.ac.at
- 24.05. - 26.05.2006 International Conference “Activities, Access, and Ageing in Southeast Asia”, Singapur
Information: Alyson Adrienne Rozells, Asia Research Institute, National University of Singapore, Shaw Foundation Building, Block AS7, Level 4, 5 Arts Link, Singapore 117570, Tel: (65) 6516 8787, Fax: (65) 6779 1428, Email: aaa2006@nus.edu.sg, <http://www.ari.nus.edu.sg/conf2006/ageing.htm>
- 16.07. - 21.07.2006 The 12th IVEVI World Conference, Kuala Lumpur, Malaysia
Information: International Council for Education of People with Visual Impairment (ICEVI), www.icevi.org/conference/worldconference.htm

Für weitere Veranstaltungen auf dem Gebiet der Entwicklungszusammenarbeit weisen wir auf den Rundbrief *Bildungsauftrag Nord-Süd* des World University Service hin. Bezug: World University Service, Koordinationsstelle *Nord-Süd im Bildungsbereich*, Goebenstraße 35, 65195 Wiesbaden, <http://www.tu-darmstadt.de/wusgermany>.

Literatur & Medien

T. Booth, M. Ainscow, D. Kingston

Index for Inclusion: Developing learning, participation and play in early years and childcare
2004

A detailed set of materials to help support early years and childcare settings to increase the participation of all children and young people in learning and play.

Bezug: CSIE, New Redland, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QU, UK,
Fax: +44 (0) 117 328 4005, www.csie.org.uk

T. Casey

Practical strategies for working with children
2005
ISBN: 1-4129-0243-6

This book makes practical suggestions and uses tried-and-tested approaches to show readers how to help children feel included and involved in play opportunities.

Bezug: Paul Chapman Publishing, 1 Oliver's Yard, 55 City Road, London, EC1Y 1SP, UK,
Fax: +44(0)20 7324 8600

Dutch Coalition on Disability and Development (DCDD)

Towards an Inclusive Policy
2005

Dutch Coalition on Disability and Development (DCDD) published a new brochure in its series 'towards an inclusive policy'. Title of the brochure: "Moving up the learning curve – inclusive development today." In it examples of good practice from projects working in inclusive development are described. These examples help to make the inclusive approach more practical and to provide guidance for making development work more inclusive. You can get a (free) brochure from DCDD's office (dcdd@dcdd.nl) or visit the brochure webpage online: www.dcdd.nl?2647

Behinderung und Entwicklungszusammenarbeit

Solidarität weltweit – was geht es uns an?

Online-Dokumentation 2005

Die Beiträge des Seminars *Solidarität weltweit – was geht es uns an? Welchen Beitrag können Selbsthilfe-*

gruppen und Behindertenverbände zur Bekämpfung der Armut leisten? sind nun als Online-Dokumentation abrufbar unter: www.bezev.de

Jeffrey D. Sachs

Das Ende der Armut
München 2005
ISBN 3-88680-830-0

Wir können die extreme Armut in der Welt abschaffen, nicht erst in ferner Zukunft, sondern in unserer Gegenwart. Das ist die Botschaft des Jeffrey Sachs, den die New York Times als den "wichtigsten Ökonomen der Welt" bezeichnet hat. In seinem Buch führt er die Erkenntnisse und Erfahrungen aus seiner mehr als 20-jährigen internationalen Tätigkeit zusammen, um ein visionäres Bild der Weltwirtschaft zu zeichnen. Es gipfelt in einem faszinierenden Programm, das Wege aufzeigt, wie auch die Menschen der ärmsten Länder am wirtschaftlichen Wohlstand beteiligt werden können (Auszug aus dem Klappentext).

Franz Alt & Rosi Gollmann & Rupert Neudeck

Eine bessere Welt ist möglich. Ein Marshallplan für Arbeit, Entwicklung und Freiheit
2005
ISBN 3-570-50069-1

Immer noch geht die Schere zwischen den Wohlhabenden und den Armen dieser Erde weit auseinander. Die Dritte Welt ist mit etwa 2000 Milliarden Euro gegenüber der Ersten Welt verschuldet und zahlt jährlich ca. neunmal mehr Zinsen, als sie Entwicklungshilfe erhält. Aber nicht nur finanziell ist die Dritte Welt – und das sind ca. 80 Prozent der Weltbevölkerung – arm dran. Ihre Bodenschätze werden in den Norden gebracht und dort verbraucht, dafür leiden die Länder des Südens überproportional an der durch Schadstoffe der Industrieländer verursachten Klimaveränderung. Was können, was müssen die Industrienationen tun, um die schreiende Ungerechtigkeit zu lindern, wenn schon nicht zu beseitigen? Ausgehend von der Tsunami-Katstrophe und von der internationalen Solidarität für die Betroffenen, fordern die Autoren einen Aktionsplan für die Dritte Welt – vergleichbar mit dem Marshallplan, der Deutschland nach dem Zweiten Weltkrieg zuteil wurde.

Bezug: Riemann Verlag

 <p>ACORN A Community Oriented Rehabilitation Network</p>	<p>Volunteer Needed: Kurdish Iraq! Development Aid! Physiotherapist! Children Rehabilitation Units Occupational Therapist! Sulaimany Kirkuk Special Education Trainer! Training local staff Ortho pedic Technician! short-term! mid-term! Serve Training local staff! Orthopedie Workshop Helping Kurdish Iraq! Helping disabled children!</p>	
<p>www.acorn.nl</p>	<p>application letter and CV to: info@acorn.nl or to: ACORN Kadikjsplein 18, 1018 AC Amsterdam, Netherlands</p>	

Netzwerk Menschen mit Behinderung in der Einen Welt

Menschen mit Behinderung in der Einen Welt ist ein Netzwerk von Organisationen und Einzelpersonen, die sich wissenschaftlich und/oder praktisch mit dem Thema Behinderung in der so genannten Dritten Welt auseinandersetzen. Mitglieder des Netzwerks können sein: Organisationen der Entwicklungszusammenarbeit, Institutionen, Arbeitsstellen an Studienstätten, Arbeitskreise und Arbeitsgruppen, Fachkräfte aus dem entwicklungspolitischen sowie behinderungsspezifischen Kontext sowie an der Thematik interessierte Einzelpersonen. Das Netzwerk ist ein Kommunikationsforum, das die wissenschaftliche und praxisorientierte Auseinandersetzung zur Thematik fördern und unterstützen will. Dies wird umgesetzt durch die ihm

angehörenden Mitglieder.

Das Netzwerk übernimmt die folgenden Aufgaben:

- Herausgabe der Zeitschrift Behinderung und Dritte Welt
- Durchführung gemeinsamer Veranstaltungen (z.B. Symposia)
- Koordinationsstelle für an der Thematik Interessierte
- Vermittlung von Kontakten
- Diskussionsforum zu relevanten Fragestellungen
- Zweimal im Jahr Netzwerktreffen in unterschiedlichen Regionen Deutschlands
- Vernetzung

Anschrift: Netzwerk Menschen mit Behinderung in der Einen Welt
c/o Behinderung und Entwicklungszusammenarbeit e.V.
Wintgenstr. 63, 45239 Essen
Tel.: 0201/40 87 745, Fax: 0201/40 87 748, Email: bezev@t-online.de
Internet: www.bezev.de

Schwerpunktthemen kommender Ausgaben der Zeitschrift Behinderung und Dritte Welt

- 1 / 2006** Menschen mit Behinderung in der humanitären Hilfe (verantwortlich: Gabriele Weigt)
2 / 2006 Wege zur Einkommensförderung für Menschen mit Behinderung in Entwicklungsländern (verantwortlich: Adrian Kniel)
3 / 2006 Regionale Perspektiven der Behindertenarbeit – Arabische Welt (verantwortlich: Susanne Arbeiter/Mirella Schwinge)

Interessierte Autorinnen und Autoren werden aufgefordert, nach vorheriger Rücksprache mit der Redaktion hierzu Beiträge einzureichen. Darüber hinaus sind Vorschläge für weitere Schwerpunktthemen willkommen.

Einsendeschluss für Beiträge

	Ausgabe 1/2006	Ausgabe 2/2006	Ausgabe 3/2006
Hauptbeiträge	15. November 2005	15. Februar 2006	15. Juli 2006
Kurzbeiträge	15. Dezember 2005	15. März 2006	15. August 2006

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